U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 November 2006

Case No: 2006-LHC-0425
OWCP No.: 5-112963

In the Matter of:

L. G.,
Claimant,

v.

CROFTON DIVING CORP.
Employer,

Appearances: Ralph Rabinowitz, Esq.
For the Claimant

R. John Barrett, Esq.
For the Employer

Before: ALAN L. BERGSTROM
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS AND DENYING SPECIAL FUND RELIEF PURSUANT TO 33 U.S.C. § 908(f)

This proceeding arises from a claim filed under the provisions of the Longshore and Harbor Workers' Compensation Act, as amended, (Act), 33 U.S.C. § 901 et. seq.

A formal hearing was held in Newport News, Virginia, on June 13, 2006, at which time the parties were afforded full opportunity to present evidence and argument as provided in the Act and applicable regulations. The Director did not appear. At the hearing, stipulations in joint exhibit 1, Administrative Law Judge exhibit 1 through 4, Claimant's exhibits 1 through 11 (less page 4 of CX 6)[1] and Employer's exhibits 1 through 10 were admitted without objection (TR 4-6).[2] The record was held open for the deposition of Dr. Petra Gurtner, M.D. and for post-hearing

[1] The following exhibit notation applies: JX - joint exhibit; ALJX – Administrative Law Judge exhibit; CX – Claimant exhibit; EX – Employer exhibit; TR – transcript page

[2] Employer's counsel objected to Page 4 of CX6 which was then withdrawn by Claimant's counsel (TR 5)

briefs. The June 15, 2006, deposition of Dr. Gurtner was received, marked, and considered as CX 12. The post-hearing written briefs filed by the respective counsel for the Claimant,[3] the Employer, and the Director were also considered.

The findings of fact and conclusions which follow are based upon a complete review of the entire record, in light of argument of the parties, as well as applicable statutory provisions, regulations and pertinent precedent.

STIPULATIONS

The parties have stipulated to, and this Administrative Law Judge finds, the following as fact (JX 1):

1. That an employer/employee relationship existed at all relevant times.

2. That the parties are subject to the jurisdiction of the Longshore & Harbor Workers' Compensation Act.

3. That the Claimant suffered a compensable injury while in the course and scope of his employment on May 27, 1999.

4. That a timely notice of injury was given to the employee to the employer.

5. That a claim for compensation was filed by the employee.

6. That the Employer filed a timely First Report of Injury with the Department of Labor and a timely Notice of Conversion.

7. That the Claimant's average weekly wage at the time of this injury was $842.70, resulting in a compensation rate of $561.80.

8. That the Employer provided Claimant with medical treatment pursuant to § 907 of the Act.

9. That the Claimant cannot return to his pre-injury employment.[4]

ISSUES

The issues remaining to be resolved are:

[3] After August 1, 2006, the Department of Labor policy requires the use of initials for claimants' name in headings and use of a descriptive title in the decision. Accordingly, "Claimant" is used in this decision vice the proper name of the individual who is the subject of this decision.

[4] This stipulation was submitted by the Employer in the post-hearing brief at page 12.

1. Whether the Employer has shown the availability of suitable alternative employment such that the Claimant is entitled to permanent partial disability benefits rather than permanent total disability benefits from April 16, 2003.

2. Whether the Claimant is entitled to continuing temporary total disability benefits from September 20, 2005.

3. Whether the Claimant was temporarily partially disabled from September 20, 2005.

4. Whether the Employer has established a qualified pre-existing disability so as to be entitled to 33 U.S.C. § 908(f) relief.

PARTY CONTENTIONS

Claimant's Contentions:

The Claimant contends, through counsel, that he injured his cervical spine during employment on May 27, 1999, and that a subsequent posterior cervical surgery on July 26, 2002, at level C5/6, has not been successful. An anterior cervical discectomy and fusion has been recommended for the cervical spine levels C5/6 and C6/7 surgery but declined by the Claimant. He has continued to decline, has consistent pain precluding restful sleep and turning his head, has upper arm muscle weakness and has lost his grip in both hands, continues to have muscle spasms, has lower back pain, and has worsening depression. Without further surgery, he reached the end of conservative medical treatment and was at maximum medical improvement on April 16, 2003. In January 2005, the Claimant's treating physician, Dr. Gurtner, again offered to perform surgery once his diabetes was under control. By October 2005, Dr. Gurtner reported increased symptoms and Claimant's medical instability to undergo cervical surgery due to increased depression. She also noted his inability to perform any of the work she had previously approved. In April 2006, the Dr. Gurtner reported continued worsening of symptoms, including increased depression and anger. Additionally, an MRI was taken, which lead to a diagnosis of a right-sided disc herniation in the lumbar spine at L5/S1.

Claimant contends he has reached maximum medical improvement since he can not undergo surgical correction of the underlying cervical problem and that, even if he had successful cervical treatment, his depression and cognitive problems preclude any useful employment. Claimant argues that he "is entitled to total permanent disability from April 16, 2003, plus penalties, interest and attorney fees."

Employer's Contentions:

The Employer, through counsel, contends that permanent total disability compensation is precluded by the availability of appropriate alternate employment and the Claimant's failure to establish a diligent work search, and that the Claimant "is entitled to permanent partial disability benefits in the amount of $281.70 per week pursuant to the [May 22, 2006] LMS." Employer notes that the Claimant began working for the Employer when he was 20 years of age and has worked over 40 years as a diver for the Employer, progressing to a supervisory position. On

May 27, 1999, the Claimant sustained a cervical injury in the course of his employment with the Employer.

In the alternative, the Employer argues that if the Claimant is entitled to permanent total disability compensation, then that status was not achieved until the June 15, 2006, deposition of his treating physician. Employer submits it is entitled to Section 8(f) relief because of pre-existing permanent-partial disability related to degenerative cervical disc disease, mild osteoarthritis left knee, diabetes, hypertension, coronary artery disease, high cholesterol, right-hand carpal tunnel syndrome, irritable bowel syndrome, anxiety, panic disorder, and depression.

Additionally, Employer argues that if maximum medical improvement is found to have been April 20, 2003, and the Claimant is found to have been entitled to permanent total disability compensation from that date, he is not entitled to continuing temporary total disability benefits and the Employer is entitled to Section 8(f) relief.

Director's Contentions:

The Director contends that the Employer has failed to establish that the Claimant had a pre-existing disability prior to May 27, 1999, that was manifested to the Employer and contributed to the Claimant's ultimate permanent disability.

SUMMARY OF RELEVANT EVIDENCE

Testimony of Claimant's Spouse (TR 12 to 20)

The Claimant's spouse appeared and testified substantially that she has been married to the Claimant for 39 years and that, up to May 27, 1999, he was a good wage earner and very active employee who worked hard and for long hours. She reported that after the Claimant was injured at work on May 27, 1999, he continued to work for about a year, though he missed a lot of work. Prior to his surgery with Dr. Koen in 2002, the Claimant had three unsuccessful epidural injections. After the July 26, 2002, surgery, he developed terrible neck spasms for which he received injections, at least one of which was Botox. Some time later the Claimant went back to Dr. Koen, who recommended surgery through the front of the neck this time. The Claimant agreed to the surgery but later withdrew because he was frightened to have it done.

The witness reported that the Claimant cannot read all the words in the newspaper, does not write well, and is not good at math. When they go to a new doctor, the witness fills out the paperwork at the office or before the appointment. The Claimant can drive very short distances but because of turning the neck, he does not trust himself to drive. When the Claimant sleeps, he gets up after three to four hours because of pain, which disturbs the declarant and causes her to sleep in another room. The witness stated that the Claimant's personality has changed from outgoing to withdrawn, he is very depressed and irritable, and he worries about his daily pain and medical condition.

On cross-examination, the witness testified she has a high school education and has worked as a legal assistant for essentially her entire marriage to the Claimant. She was familiar with the fact

that Dr. Miller has been the family doctor for years, but does not remember if he had diagnosed Claimant with an anxiety disorder or sleep disorder prior to the accident. She reported that the Claimant is very nervous, anxious, and irritable now. She stated that the Claimant was prescribed Valium at some point prior to the accident, that he does not like doctors much, and that he has a good memory. She reported that the Claimant was proud of his work, interacted with Naval officers, and was the face of Crofton Diving.

On redirect examination, the witness testified that the Claimant took Valium for seven years and stopped so he would not continue to be addicted to the medicine and now declines taking the medicine to avoid addiction.

Testimony of Claimant (TR 20 to 37 and 78 to 79)

The Claimant testified that he was born on May 2, 1940, and is 66 years old. He stated that he left school at age 15 in the fifth, sixth, or seventh grade. He then worked for his father on a fish boat, worked in construction, and worked as a tug boat captain for a couple of years before starting to work for Crofton in 1960 at age 20. By the May 1999 accident, approximately 17,000 hours of Claimant's work with Crofton was dive work, which he would do even if injured, such as when he broke his fingers and hand. His last few years of work with Crofton were spent as a dive supervisor of a three-man team in Newport News Shipyard. As supervisor, he helped the young divers along, carried hard-hat diving material, pulled hatches, and lifted. A regular compressor weighs about twenty-three pounds, dive helmet about sixty-five pounds, and lightweight helmet about nineteen to twenty pounds. He reported that he never filled out a dive log and would either call it into the office or a younger team diver would fill out the log for him. If reading was required on the job, he would get another team member to read for him.

He testified that Dr. Gurtner, a neurosurgeon, has been his main doctor since August 2003. He stated that he had recently visited Dr. Gurtner and she would not operate on him at this time because of his health and that he to have an MRI of the brain performed. He stated that when Dr. Koen operated on his neck, it had been through the backside and that when he later visited Dr. Koen, the doctor wanted to do another surgery on his neck through the front. He reported that he chickened out of the second neck operation because of the pain from the first operation. He saw Dr. Ordonez for a second opinion on the neck surgery and was referred to Dr. Doyle for emotional problems. Dr. Doyle had Claimant's family doctor, Dr. Miller, prescribe Zoloft and a sleeping pill, which he now takes. He stated that his head will usually roll off the pillow around 3:00AM and he is then up all night after three or four hours of sleep. He reported that his current pain includes burning in the shoulders and neck pain, as well as spasms which are nauseating and upset his stomach. He reported about four weeks of sciatic nerve, left leg, and hip pain, with three toes on each foot and left foot going to sleep. He stated that his thumb and two fingers go to sleep, he cannot close his hands, and his arms have shrunk in size. He stated that his condition has become worse since his operation. He reported that he has become weaker and now has low back problems perhaps from just sitting in a chair now after a long time as a diver pulling all types of weights. He reported that he walks with a list, which may be related to his back or neck, but he is not sure why.

The Claimant testified he would work if he could, but he cannot think of any job he could do because he hurts and can hardly get in and out of a car anymore. He reported that when he was on Valium for seven years it was for a spastic colon and when the specialist stopped the medicine he had a reaction to the sudden stop. He dislikes taking pain medication because it only hides the pain and upsets his stomach.

On cross-examination, the Claimant testified that he is 6'2" and weighs 205 pounds after losing forty pounds. He reported that his diving assignments were primarily for the Navy but would also be at dams, river-crossings, cables, or submarines. He stated that, when on the job, he was responsible for safety of his divers and would deal with shipyard superintendents and chief engineers. He had a classified clearance for work on submarines. He has a driver's license without restrictions.

The Claimant reported that his family doctor, Dr. Jonathan Miller, had diagnosed him with diabetes prior to 1999. He stated that he has high blood pressure and that Dr. Miller has treated him for anxiety because of the Valium. He stated that he probably had some sleep problems prior to 1999. He has not seen a medical provider since November 2005, in part over concern about bill payment, but prior thererto he had seen Dr. Miller for diabetes and heart concerns. He saw Dr. Stine in the past for his heart and the doctor found four blockages. All the doctors the Claimant has seen want him to walk and no doctor has told him that his back and leg pains were from diabetes.

On redirect examination, the Claimant stated that pain raises his blood pressure and sugar level. He reported that the sleep problems he had before the accident were not like the sleep problems he has had since.

During the Claimant's case in rebuttal, the Claimant testified that he saw Ms. Byers on May 9, 2006, the appointment was for 9:00AM, that Ms. Byers appeared at approximately 9:25AM, and the appointment ended around 11:30AM. He reported Ms. Byers told him he was in the 90 percent range for people his age. He stated that he asked Ms. Byers about Dr. Gurtner disapproving some of the listed jobs and Ms. Byers acted as if she did not know anything about it.

Testimony of Barbara Byers (TR 38 to 78)

The Employer called Ms. Byers, who testified that she is a licensed professional counselor, certified rehabilitation counselor, vocational counselor, and case manager. She has a bachelor's degree and some graduate work in psychology and a master's degree in rehabilitation counseling. She is also a hearing officer for the Department of Rehabilitation Services and Department of the Blind and Visually Impaired for the Commonwealth of Virginia. EX 4 contains a current copy of her resume.

The witness stated she met with the Claimant on May 9, 2006, for a vocational evaluation interview and vocational testing. She administered the Woodcock Mini-Battery Achievement test which tests reading, writing, math, and factual knowledge. The Claimant scored a low average in reading, below average in mathematics, well below average in writing, and average in

factual knowledge. During the interview, they discussed the Claimant's medical treatment, medications, work history, education, and work duties and responsibilities as a diver for Crofton. She defined "transferable skills" as skills which have been obtained through education, training, or work history which are useful in a new job. She reported that the Claimant had an excellent work history as a dive superintendent, had supervised jobs for many years, interacted well with customers, had excellent customer service skills, could oversee safety at the worksite, provided information for log entries, and was a very skilled diver.

In making her determinations, the witness stated she considered the medical restrictions of "no lifting, pushing or pulling beyond 10 pounds, no overhead work or repetitive bending." She reported that the Claimant's lack of a high school education would impact on those jobs requiring such an education, but some employers accept an excellent work history, such as the Claimant's, in lieu of a GED or diploma, and there are jobs that do not require a high school diploma at all.

While examining EX 4, the witness testified that it contained a labor market survey she had compiled and indicated that the jobs she felt the Claimant could perform were on pages 31 and 32. She stated that the Claimant's presentation and ability to interact with people are excellent assets and appropriate for such jobs in public places as cashier, museum guide, unarmed security guard, parking cashiers, toll collectors, and automobile parking lot attendants. She stated that the Claimant's mathematics test score would not prohibit work as a cashier because handling cash is different than doing math problems on paper, cash registers are very user friendly and bring up the amount of change, and counting money and customer service are skills. She reported that she had interaction with all the employers listed on the two pages, had visited several of the listed job sites, and was very familiar with the job requirements. She stated that the current wages of the listed jobs ranged from $6.00 to $9.00 per hour and that, in 1999, they paid between $5.25 and $6.00 per hour.

The witness testified that the labor market report beginning on page 8 of EX 4 was one she prepared May 17, 2005, without the benefit of meeting with the Claimant. Several of the jobs listed in the 2005 report dropped off after she interviewed and tested the Claimant. She testified that the dispatcher jobs on the 2005 list were not appropriate for the Claimant because they required a high school diploma and the ability to type and write.

The witness reported that the formal testing of factual knowledge, which was done verbally, is a measure of science, social studies and humanities knowledge, and equates to an Intelligence Quotient ("IQ"). The Claimant's IQ was average at 98. The other formal testing had some writing and some dictation. The witness opined that the Claimant was currently employable in the job market.

On cross-examination, the witness testified that the case file was referred to her in March 2005, and her understanding was that the Claimant was a diver supervisor and that she had no reason to look at the job skills necessary for a diving superintendent. In her report she used the restrictions placed on the Claimant by Dr. Gurtner on January 28, 2005, which were the same restrictions Dr. Spear had assigned in 2003. She reported that the records from Dr. Doyle did not include any work-related restrictions. She stated that her initial report (EX 4 at 9) was submitted to Ms.

Webb and identified jobs the Claimant could perform based on his physical capabilities and work history. However, the initial report was not based on his educational level because she did not have that information at that time. She reported that the first time she knew the Claimant's educational level was after she received a copy of the Claimant's deposition of February 14, 2006. She stated that the first list of jobs sent to Dr. Gurtner (EX 4 at 18) was a standard form letter and included a statement that education was considered because the statement was not picked up before the letter went out.

The witness testified that she reviewed Dr. Gurtner's and Dr. Doyle's records on the Claimant prior to meeting with the Claimant on May 9, 2006. She stated that she only considered the work restrictions related to his work injury and did not consider Dr. Gurtner's June 22, 2005, statement that "due to his other medical conditions, in particular, a significant Type II diabetes, along with coronary artery disease and hypertension, is not able to tolerate a stressful work environment. I hope this will be taken into consideration when identifying employment options . . . ." She stated that she was aware of Dr. Doyle's diagnosis of recurrent severe major depression and she had considered it, but she had not assigned any work restrictions because of that diagnosis. She testified that most of the jobs she found were non-stressful and that she only considered the work restrictions assigned of no more than 10 pounds pulling or lifting and no overhead work or repetitive bending.

The witness testified that Dr. Gurtner's statement related to the Claimant's inability to perform jobs was made in consideration of all the Claimant's medical conditions including diabetes, high blood pressure, and low back pain, but her job was to find jobs the Claimant could perform with regard to his cervical injury. She stated that she was unaware "that any of his physicians had assigned restrictions because of any other problems." She reported that she was aware of a previous functional capacity evaluation of the Claimant which put him in the sedentary range of work with regard to lifting and the light range of work with regard to walking. She disagreed with the characterization of work by the physical therapist administering the functional capacity test as sedentary because there were no restrictions on standing and walking.

The witness stated that prior to meeting with the Claimant she had the benefit of reviewing the test report of Amy Broschart, who is a certified rehabilitation counselor. After reviewing CX 6, the witness testified that the correct measure for comparing achievement test skills among individuals within a matrix is the standard score and not a grade level. She reported that in her testing, she administered one test to get a standard score. She stated that during her interview, the Claimant reported his subjective complaints that he could not walk one block, he is limited in standing and sitting, he awakens at night, is unable to sleep, and has low back pain. She reported the Claimant advised her that Dr. Gurtner stated he could not go back to work and that he had not returned to Dr. Doyle because some bills had not been paid. She stated that the Claimant does not really know how to use a home computer and had reported he cannot turn his head either way when he drives, he no longer builds model vessels, and he cannot do yard work anymore. She acknowledged that the Claimant reported to her that he feels terrible and lays down two or three times each day because of pain.

The witness stated that CX 11 contained testing reports for achievement at grade 7, basic skills at grade equivalent 3.6, writing at grade equivalent 4.4, writing grade equivalent at 2.1, math grade

equivalent at 5.2 and national current equivalent at the first percentile. She reported that she completed her forms using a computer formatting and that information blanks in CX 11-1.5 are related to the information contained in the printout in CX 11-1.1 and 11.3.

She testified that, from her first labor market survey, the position of security guard in the CTR Group is still an appropriate job for the Claimant. She reported that there is a test to take, not all security people have to keep logs, that in some positions the only writing is putting a time down when rounds are made, and they have to be on their feet. The next appropriate job from the first report is service valet for cars, which does not require employees to keep cars from being stolen. The job at Greenbrier Volkswagen involved driving cars around the dealer's lot. She reported her impression that the Claimant drives and does not have any restriction against driving. She reported that a requirement to patrol area to prevent theft from parked automobiles is similar to unarmed security guard. She stated that the job with George Sheely was available in May 2005, when the report was done, that she would not be surprised if the job required the Claimant to pick up an object that fell from the work table, and that the Claimant was restricted for repetitive bending.

The witness testified that the 2006 report listed Greenbriar Chrysler and Hall Mitsubishi jobs as a lot attendant and that these jobs fall within the Claimant's physical capabilities. She reported that the cashier work listed was entry level and the cashier museum guide requires the individual to be on their feet a lot. She reported that she is not a medical doctor and does not assign physical restrictions but uses the physical restrictions assigned by the physicians in determining appropriate jobs. She reported that cashier work may be busy and you do have to keep up with your customers, but it is not stressful. She stated that the Claimant had no restrictions with regard to stress or working at a busy pace. She did not consider any restriction that the Claimant should not be in stressful positions. She stated that it is hard to understand how taking money from people driving through a toll booth would be stressful.

The witness reported that she was thirty minutes late for her interview with the Claimant, which was supposed to start at 9:00 AM, the interview ended before noon, and it took about two hours.

On redirect examination, the witness testified that in the functional capacity evaluation it reported that sitting tolerance was 67 to 100 percent of the day, intermittent; standing tolerance was 34 to 66 percent of the day; walking was 6 to 33 percent, or 1/3, of the day; and that she considered these restrictions in making the job evaluations. She reported a sedentary job is performed generally seated and does not require lifting 30 [sic] pounds while light jobs can require lifting up to 20 pounds or no lifting but sitting and walking are required. According to the functional capacity evaluation, the Claimant would be classified as light capabilities rather than sedentary. She stated that in her test reports, "ss" refers to standard score, and 100 is exactly average, with a 10 point standard deviation.

Upon examination by the Administrative Law Judge, the witness testified that she used the restrictions of no lifting 10 pounds, no push or pull as described by the doctor, and no repetitive bending, as well as the standing and walking portion of the functional capacity evaluation.

Medical Entries by Dr. Petra Gurtner, M.D. (CX 1 and EX 9)

CX 1 and EX 9 contain medical record entries from Dr. Gurtner. On January 6, 2004, the Claimant presented to Dr. Gurtner for a third opinion on follow-up cervical surgery. He reported complaints of severe neck pain, sharp pain between the shoulders exacerbated with any lifting or pulling, numbness and tingling in the first three fingers of each hand, weakness in both hands, some shakiness in the hands at times, poor balance, and erectile dysfunction since 1999. His past medical history was significant for Type II diabetes, coronary artery disease and hypertension, as well as anxiety and depression. His medications were documented as Clipiside XL bidaily, Altace, and a muscle relaxer as needed. He has not worked as a diving supervisor for the past two years secondary to restrictions.

Upon examination, the Claimant was found to be 6 feet tall, his neck incision was well healed, he had palpable neck spasm in the cervical and upper thoracic region particularly on the right, and he had no atrophy or fasciculations. His cognition, fund of knowledge, and memory appeared appropriate. Dr. Gurtner opined that he had a slight depressed affect. He had decreased sensation in the hands, but not along any dermatome, and his grip was 4/5. Foot sensation and position sense were decreased. Deep tendon reflexes were increased in the left lower extremity. There was mild asterixis and some course tremors in the upper extremities. Mild gait ataxia and mild dysmetria were present. The December 2003, MRI revealed site of prior posterior foraminotomy, neurforaminal narrowing at C3/4 left, C5/6 and C6/7, and no significant cord compression. Dr. Gurtner stated the Claimant would not benefit from further surgery at this point and conservative treatment of the muscle spasm was indicated. She recommended the Claimant get better control of his diabetes and she recommended and another MRI in one year. The Claimant was told not to lift or pull beyond ten pounds, perform overhead work, or perform repetitive bending. He was instructed to return in one year with a new MRI. Dr. Gurtner also prescribed Flexeril, three months physical therapy for the muscle spasm, and Neurotin.

A January 5, 2005, cervical MRI by Dr. J.W. Pinkston, M.D. revealed no fractures, destructive bone lesions, or other acute bone abnormalities. At C3/4 was moderate left joint osteophyte with moderate to marked left foraminal narrowing, unchanged from the December 22, 2003, MRI. At C4/5 was bilateral joint osteophyte with mild right foraminal narrowing and mild to moderate right foraminal narrowing, unchanged. At C5/6 was mild disc narrowing, disc bulging and ridging with moderate bilateral foraminal narrowing right greater than left, unchanged. At C6/7 was disc bulging and left disc protrusion effacing the thecal sac by 3 mm to the left foramen with mild left foraminal narrowing greater on the left, no significant change. No abnormality was reported for C2/3 and C7/T1. The overall impression was degenerative disc disease most marked at C5/6, unchanged degenerative forminal narrowing, left disc protrusion at C6/7 mildly effacing the thecal sac, also unchanged.

The Claimant returned to Dr. Gurtner on January 12, 2005, following the January 5 cervical MRI. He reported continuing numbness and tingling in the first, second and third fingers of his right and left hands and a loss of strength in both hands. Additionally, he complained of numbness in the first, second, and third toes on his left foot. He stated he was having a great deal of trouble sleeping and could only sleep with several pillows propping his head up. He also stated that he could not straighten his neck at all. Dr. Gurtner noted that, to date, he had received multiple injections to his neck, but had not shown any improvement. She reviewed the January 5

MRI and noted essentially no change. She did note degenerative disc disease most marked at C5/6 involving the foramina on the right more than the left and disc disease at C6/7 more on the left than the right. Upon examination, Dr. Gurtner found that the Claimant had more muscle spasm than at his previous visit. The Claimant could not extend his neck at all and could almost not rotate his neck. Dr. Gurtner noted that the Claimant continued to be slightly depressed. He had decreased sensation in both hands, decreased grip, and a loss of sensation in both feet. He was also experiencing weakness in his left biceps and triceps. Dr. Gurtner opined that the Claimant's MRI was essentially unchanged and his clinical exam was slightly worse than the prior year. Dr. Gurtner offered surgery directed to C5/6 and C6/7, but since the Claimant's diabetes was still poorly controlled, she advocated maximizing his glucose control and then reassessing.

On February 28, 2005, Dr. Gurtner responded to a letter from the Claimant's nurse case manager regarding his work restrictions. Dr. Gurtner stated that the prior restrictions she had given him would remain in place, even if the Claimant chose not to have surgery. She also stated that a functional capacity evaluation would not be helpful in this case.

In a June 22, 2005, letter, Dr. Gurtner explained that the rationale behind the Claimant's restrictions was: "[e]xcessive lifting, repetitive bending or overhead work would exacerbate the already existing neuroforaminal stenosis at C5-6 and C6-7. By this he would lose more neurological function." Dr. Gurtner opined that a functional capacity evaluation would not be helpful and that the Claimant, due to his diabetes, coronary artery disease, and hypertension, would not be able to tolerate a stressful working environment.

The Claimant returned to Dr. Gurtner on October 6, 2005, because of increased neck pain, weakness in both hands, and weakness in his left foot and left sciatica. She stated that the Claimant appeared quite depressed and he had quit taking all his medications for the previous two months. Upon examination, Dr. Gurtner noted that the Claimant had lost approximately twenty pounds and he had elevated blood pressure. He had severe muscle spasm in the cervical and the lumbar spine. Additionally, he could not extend his neck at all and could not lie down unless he had two rolled up pillows supporting his head. He also had decreased sensation in all four extremities and decreased grip. Dr. Gurtner opined that the Claimant's findings were suggestive of depression and possibly progression of the cervical stenosis. She ordered an MRI of the cervical spine and an MRI of the lumbar spine. She renewed his prescription for Altace and Cliposide and prescribed Elavil. She then advised the Claimant to see Dr. Doyle for a consult for chronic pain and depression.

On October 18, 2005, Dr. Gurtner sent a letter to the Claimant's nurse case manager. In that letter, she stated that she could no longer approve the Claimant for the jobs of dispatcher, police telecommunicator, contact lens lab technician inspector, small parts assembler, travel counselor service representative, lot attendant valet, or unarmed security guard. She based this opinion on the Claimant's physical examination of October 6, as well as his work history and education.

The following day, Dr. Daniel S. Kothmann performed an MRI of the Claimant's lumbar spine. The MRI revealed no abnormalities at L1/L2, mild posterior disc bulges without significant mass at L2/L3 and L3/L4, moderate disc degeneration with a broad posterior disc bulge and a broad

superimposed right posterior/posterolateral disc protrusion at L5/S1, and mild lower lumbar degenerative facet changes.

In a letter to Dr. Miller on October 26, 2005, Dr. Gurtner detailed the results of the lumbar spine MRI. Additionally, she stated that the results of the Claimant's MRI of the cervical spine, also taken on October 19, 2005, were essentially unchanged from the January 5 MRI. Dr. Gurtner noted that the Claimant had resumed his care for hypertension and diabetes. She stated she would set the Claimant up for the anterior cervical discectomy and fusion at C5/6 and C6/7 when his depression had lifted and he was medically stable to undergo surgery.

The Claimant returned to Dr. Gurtner on April 20, 2006. He complained of severe neck spasms with pain in both upper extremities. He stated he had been having more trouble with his left hand and had more left side sciatica. He also complained of muscle twitching in his leg muscles, which was totally involuntary and worrisome. He stated he had seen Dr. John Ward on January 24, 2006, and Dr. Ward advised him to proceed with the recommendations of Dr. Gurtner. Dr. Gurtner noted she still found the Claimant to be severely depressed and angry, and she was not sure if he would be able to handle more surgery. On physical examination, Dr. Gurtner noted the Claimant had lost about twenty-five pounds since his last visit. The Claimant had severe limited range of motion in his neck and he could not lie flat. Dr. Gurtner observed myoclonus spontaneous fasciculations in both lower extremities. The Claimant had weakness in his left biceps and triceps. The grip in his left hand was 4- out of 5, while the grip in his right hand was 4 out of 5. He also had decreased sensation in the first two fingers of his right hand. He had decreased strength in both lower extremities, which was at best 4 out of 5. His gait was ataxic and his deep tendon reflexes were decreased. Dr. Gurtner also observed a positive Lasegue's on the right at twenty degrees and on the left at forty degrees. Dr. Gurtner was concerned that the Claimant's cervical disease was progressing and she determined he needed another MRI of the cervical spine. She also advised the Claimant to follow up with Dr. Miller about possible electrolyte disturbance. She prescribed Flexeril and aqua therapy three times per week for sixteen weeks for the Claimant's neck spasms.

On April 27, 2006, Dr. Pinkston performed and MRI of the Claimant's cervical spine. The MRI revealed very little change overall. At C3/C4, there was moderate to marked left foraminal narrowing created by a left unconvertebral joint osteophyte. At C5/C6, there was moderate bilateral foraminal narrowing and the prominent right posterior osteophyte, described as a disc osteophyte complex in the previous MRI appeared primarily osteophytic. At C6/C7, there was a left posterior disc osteophyte complex protruding 3-4 mm and moderate to marked bilateral foraminal stenosis appeared slightly worse.

On May 16, 2006, the Claimant returned to Dr. Gurtner with the new MRI of the cervical spine. The Claimant complained of new numbness in the left side of his face. Dr. Gurtner ordered an MRI of the brain to rule out a neoplasm or multiple strokes.

Medically Related Reports of Psychologist William W. Doyle, Jr., PhD. (CX 2 and EX 10)

CX 2 and EX 10 contain medical record entries from Dr. Doyle. The Claimant saw Dr. Doyle, a psychotherapist, on October 17, 2005, for an initial evaluation. His presenting problem was

increasing irritability and depression. The Claimant stated that he is sometimes in so much pain he breaks out into a sweat. He reported his temper has been worsening and he is starting to verbally lash out. He stated that he feels depressed and gets irritable with his wife, which he later regrets, but denied physically abusing his wife. He also reported that "he feels a profound sense of loss now that he is no longer able to work as a diver." Since his 1999 accident, he reported sleep disturbance because of numbness and pain and said he only gets about four hours of sleep a night. His wife sleeps in a separate bedroom because of his restlessness and he experiences insomnia. The Claimant denied attempting suicide or any other self-injurious behavior. He complained of decreased appetite and stated he has lost about twenty seven pounds over the last few months. He also complained of constipation beginning around the time he started taking amitriptyline. He stated that he used to smoke three packs of cigarettes a day, but he quit twenty five years ago. Additionally, he denied abusing alcohol or drugs. The Claimant told Dr. Doyle that, while going through a divorce from his first wife, he had one therapy session. He reported that the therapist wanted him to take medication, but he did not want to. Dr. Doyle noted that the Claimant did take Valium for seven years for a nervous stomach.

Dr. Doyle noted that the Claimant left school in eighth grade because he did not do well. He worked for his father on a tugboat for a while and then worked for the railroad before becoming a diver. Dr. Doyle stated that the Claimant was very proud of his 45 year work history with the same company. Upon mental examination, Dr. Doyle noted the Claimant was mildly agitated and his mood was depressed. The Claimant was attentive and cooperative, but his demeanor suggested irritability. Dr. Doyle rated the Claimant's depression as moderately severe. He denied anxiety attacks, but said he sometimes feels shaky. He reported that he had only cried once recently, because his disability payments were reduced. His thinking was rational and coherent, with no evidence of thought disorder. Moreover, there was no evidence of mood swings, hypnomania, or mania, and he denied hallucinations and delusions. His insight was fair and his judgment was adequate. Dr. Doyle opined that the Claimant's intellect was estimated to be in the average range; however, the Claimant expressed "despair" about working jobs that require an education. He also stated that he is skeptical of and angry at doctors because he has not gotten much relief from his symptoms. Dr. Doyle diagnosed the Claimant with major depression, recurrent, severe and his treatment plan included four or five therapy sessions before reevaluation.

Between October 31 and November 28, 2005, the Claimant returned to Dr. Doyle four more times. During these sessions, the Claimant repeatedly told Dr. Doyle about his job performance and responsibilities "pridefully." He also related that he feels he has lost self-esteem and his "role, status, physical strength, [and] physical ability." He stated that he could not turn his neck and that the limitations Dr Gurtner placed on him were "for life." He also complained of a loss of restorative sleep and general health. He stated that he did not know whether the depression or pain and irritability prevented him from getting a good night's sleep. The Claimant felt all he had "gained" in return was pain, a lower standard of living, depression, irritability, and Workers' Compensation problems. Dr. Doyle opined that the Claimant was "suffering, both physically and emotionally, ambiguous losses of work, physical strength, agility, source of pride/esteem, health/fitness, [and] identity." He also stated that the Claimant's depression and irritability were exacerbated by the reduction in Workers' Compensation payment.

At the session on November 14, Dr. Doyle tried to convince the Claimant to take an anti-depressant medication, but he resisted. However, at the next session, the Claimant gave Dr. Doyle permission to speak with Dr. Miller about the possibility of prescribing medication after Dr. Doyle explained the benefits.

Medically Related Reports of Dr. Joseph L. Koen (CX 3)

CX 3 contains sixteen medical record entries from Dr. Koen. The Claimant saw Dr. Koen on December 17, 2001. The Claimant complained of right-sided neck and shoulder pain, numbness in the first three fingers of his right hand, and weakness. He was able to reproduce the numbness with neck maneuvers. The Claimant told Dr. Koen he had been climbing down a ladder five weeks prior to this visit, when he had left hand numbness, diaphoresis, and nausea. The Claimant then had a cardiac workup which showed three blockages. Dr. Koen noted that the Claimant had been diagnosed with degenerative cervical spine disease and right carpal tunnel syndrome by Dr. Robert Rashti. Dr. Koen also noted that the Claimant suffered from coronary artery disease, hypercholesterolemia, hypertension, and diabetes. Upon examination, Dr. Koen noted that the Claimant was alert, oriented, and his mental status was normal. Cranial nerves II through XII appeared to be intact and detailed motor examination revealed 5/5 strength. He had spasm in the right trapezius. Sensory examination to pin prick, light touch, and vibration was intact. Phalen's test and Tinel's signs were negative. His reflexes were at zero in the right biceps, 2+ in the left biceps, and trace in the triceps and lower limbs. His cervical range of motion was done very well. Dr. Koen's impression was that the Claimant had right C6 radiculopathy and right carpal tunnel syndrome. Dr. Koen elected to give the Claimant epidural steroid injections.

The Claimant returned to Dr. Koen on March 13, 2002. He had undergone three epidural steroid injections. Dr. Koen stated that overall, the Claimant was better.

On May 1, 2002, the Claimant returned to Dr. Koen for a follow up. The Claimant still complained of numbness in the first three fingers of his right hand, even after three epidural steroid injections. Dr. Koen suggested surgery for the Claimant's cervical radiculopathy and the Claimant said he wanted to think about it.

The Claimant went to Dr. Koen for another routine follow up on July 10, 2002. He continued to complain about discomfort in his right arm and the first three fingers of his right hand. He also complained about similar symptoms in his left hand, which he could reproduce with head motion. He stated that the symptoms interfere with his daily activity. Upon examination, Dr. Koen noted that the Claimant still had significant limitation on cervical extension. Dr. Koen ordered an MRI of the Claimant's cervical spine.

On July 12, 2002, the Claimant underwent an MRI of the cervical spine. Dr. Kothmann noted mild to moderate cervical spondylosis with multifocal neural foraminal narrowing by osteophyte formation at C3/4, C4/5, C5/6, and C6/7. He also noted that at C6/7, there was a left posterior disc protrusion without significant mass effect. There was no cord abnormality or canal stenosis or subluxation demonstrated.

On July 17, 2002, the Claimant went to Dr. Koen to discuss surgery. Dr. Koen determined the surgery would be easiest with a posterior foraminotomy over the right C6 nerve root. The Claimant was cleared for surgery by Dr. Stine. Dr. Koen performed surgery on the Claimant on July 26, 2002. There were no complications.

On August 21, 2002, the Claimant saw Dr. Koen for follow up after surgery. The Claimant told Dr. Koen he could not believe how much better he felt. However, he did complain of discomfort in the third finger of his left hand. Dr. Koen opined that the Claimant was doing very well.

The Claimant returned to Dr. Koen on September 18, 2002. He complained of muscle spasm and discomfort in his right shoulder. He also complained of a knot in the trapezius. He told Dr. Koen he had slept on his right arm one night and awoke with a tingling in his fingers, but it dissipated. Upon examination, Dr. Koen noted that the Claimant had some restricted range of motion on right rotation. The Claimant also had spasm on palpitation. Dr. Koen gave the Claimant Flexaril and a Medrol Dosepak.

On October 30, 2002, the Claimant saw Dr. Koen again. He complained of neck stiffness, some numbness in his left index finger, and numbness in his right thumb. He stated that his neck discomfort gets worse when the weather changes. Dr. Koen examined the Claimant and noticed some spasm in the trapezius. Dr. Koen recommended the Claimant take Motrin and continue physical therapy.

On December 11, 2002, the Claimant went to Dr. Koen, continuing to complain of neck tightness and spasm. He stated that some of the physical therapy was causing neck spasm as well. Dr. Koen opined that further surgery would not benefit the Claimant.

The Claimant returned to Dr. Koen on June 4, 2003. He complained of bilateral shoulder pain and residual paresthesia in the first three digits of his right hand. The Claimant had just finished treatment with Dr. Spear and had trigger point injections. On examination, Dr. Koen noted mild restriction in the Claimant's cervical range of motion, and mild weakness in the deltoids, biceps, triceps, and interossei. The Claimant had mild atrophy in the triceps bilaterally and was areflexic in his upper limbs. He had decreased pin prick in the C6 and C7 distributions that was greater in the right than the left. Dr. Koen sent the Claimant for another MRI of the cervical spine before deciding whether further surgery would be beneficial.

On June 24, 2003, the Claimant had another MRI of the cervical spine. Dr. Pinkston noted degenerative disc disease at multiple levels, but most marked at C5/6. At C6/7, he noted a small left posterior disc protrusion. At C3/4, C4/5, C5/6, and C6/7, there was degenerative foraminal narrowing present. There was no significant spinal canal stenosis and no interval change.

The Claimant followed up with Dr. Koen on July 7, 2003. Dr. Koen reviewed the MRI results and determined the Claimant was symptomatic from progressive degenerative cervical spine disease. Dr. Koen suggested anterial cervical discectomy and fusion with plating, but he could not predict the degree of possible improvement.

On August 8, 2003, Dr. Koen sent a letter to the Claimant's medical case manager. He stated that the Claimant's work injury resulted C5/6 and C6/7 herniations. He also opined that, while the progression of the Claimant's disc disease was not due to an injury, the injury initiated the process of degeneration.

The Claimant returned to Dr. Koen on September 17, 2003, to discuss surgery. The Claimant complained of neck pain radiating into the bilateral shoulder and scapular regions and into the flank and radiating discomfort into his arms and forearms. He also complained of paresthesia into the second and third toe of both feet. The Claimant told Dr. Koen that he had seen Dr. Ordonez for a second opinion. Upon examination, the Claimant's cervical range of motion was decreased and he had weakness in the biceps, triceps, and interossei. Dr. Koen stated that the Claimant had failed conservative treatment and would benefit from C5/6 and C6/7anterior cervical discectomy and fusion with bone graft and plating. The Claimant elected to proceed with iliac crest bone grafting.

Medically Related Reports of Dr. Robert M. Spear (CX 4 and EX 1)

CX 4 and EX 1 contain the same medical record entries from Dr. Spear. Dr. Spear first saw the Claimant on January 8, 2003, on the recommendation of Dr. Koen. The Claimant's chief complaint was right shoulder pain with occasional numbness and spasm. He described the pain as a constant ache that waxes and wanes in intensity. He also complained of tingling and numbness in his right upper extremity more than his left, but had nearly constant symptoms in the junction of his neck, upper back, and upper trapezius area. He rated his average daily pain 6 or 7 out of 10. He told Dr. Spear he had severe nighttime pain that would occasionally awaken him. The Claimant also complained of headaches, weakness in his right upper extremity more than his left, depression, occasional numbness in the first three digits of his right hand, transient and positional numbness of the first two digits of his left hand, and compression in the upper back muscles. Upon examination, the Claimant was found to have normal pin prick and light touch throughout all dermatomes bilaterally in the upper and lower extremities. His muscle stretch reflexes were 1+/4 bilaterally throughout the biceps, triceps, pronator, patella, and Achilles. His motor strength was measured at 5-/5 strength throughout the deltoid, biceps, triceps, wrist extensors, hand intrinsics, and iliopsoas, and 5/5 in the quadriceps, hamstrings, tibialis anterior, and extensor hallucis longus. Dr. Spear also noted primary myofacial findings in the bilateral upper trapezius, right splenius, cervicis, right levator scapula, and right scaline. Dr. Spear's diagnoses included residual myalgia myositis in the cericothoracic region and recent onset of Bell's palsy. Dr. Spear treated the Claimant with Lidocaine injections.

On January 15, 2003, the Claimant saw Dr. Spear for a follow up. The Claimant complained of increased pain, even with trigger point injections and physical therapy. Upon examination, Dr. Spear noted no change from the prior visit. Dr. Spear instructed the Claimant not to work at this point in time. The Claimant again was treated with injections.

The Claimant returned to Dr. Spear on January 22, 2003. He continued to complain of headaches and symptoms in his right upper extremity. Upon examination, Dr. Spear noted the Claimant was essentially unchanged from the prior visit. However, he did note that the Claimant's Bell's palsy was improved. The Claimant then had more injections.

On February 5, 2003, the Claimant returned for another round of injections. He complained of occasional radiation into right upper extremity and he stated that he pulled back a heavy door with his arm fully extended, which seemed to cause more problems. His examination was essentially unchanged from prior visits.

On February 19, 2003, the Claimant returned to Dr. Spear. He admitted having a better range of motion after the injections, but stated he was still uncomfortable in the morning. He complained of transient paresthesia in the first three digits of his right hand, more than his left hand. Objectively, the therapist felt the Claimant was 25-30% improved since beginning the injections, even thought the Claimant did not admit subjective improvement. Upon physical examination, Dr. Spear found the Claimant was essentially unchanged from the prior examination. The Claimant then had injection treatment.

The Claimant returned for injections on March 5, 2003. He had no new complaints and his physical examination was essentially unchanged. On March 12, 2003, he returned, complaining of waxing and waning symptoms in his upper extremities and in the first three digits of his right more than his left. His physical examination was unchanged. The Claimant was then injected with myobloc/botulinum toxin, rather than Lidocaine.

On April 2, 2003, the Claimant returned. He stated he had felt mild improvement with the botulinum toxin injections, but had raked leaves the day before and now felt as if his right upper back and neck had returned to pre-injection status. He also complained of occasional numbness in the first three digits of his right hand. Dr. Spear found the Claimant's physical examination unchanged. He was then injected with Lidocaine.

Oh April 16, 2003, Dr. Spear, the Claimant, his medical case manager, and his physical therapist had a counseling session. At this point, Dr. Spear stated that, while therapy and injections had made an improvement, the Claimant had "reached a state of plateau with regards to further physical therapy efforts." In Dr. Spear's opinion, further treatment was unlikely to lead to any significant improvement in the Claimant. Dr. Spear also told the Claimant that he had vocational rehabilitation possibilities and, in his opinion, the Claimant is "an extremely valuable resource for the community" and he felt that the Claimant should look forward to a new career. After the discussion, the Claimant complained of increasing spasm in the right upper back and requested examination and treatment. Upon physical examination, the Claimant was essentially unchanged. Dr. Spear noted there was evidence of mild dural tension in the right upper extremity with primary myofascial findings in the right upper trapezius, right levator scapula, and scalene. The Claimant was treated with Lidocaine. Dr. Spear told the Claimant to undergo a functional capacity evaluation, which he would review to make recommendations. From a physiatric standpoint, Dr. Spear opined that the Claimant had reached maximum medical improvement.

The Claimant returned on April 30, 2003, after his functional capacity evaluation. Dr. Spear reviewed the evaluation and determined the Claimant was capable of sedentary duty only and was categorically unable to return to his previous job. Dr. Spear encouraged the Claimant to get involved in a vocational rehabilitation program to set him up to use his mind instead of his body.

On October 1, 2003, the Claimant went to Dr. Spear for reevaluation. Upon examination, the Claimant's physical condition was essentially unchanged. Dr. Spear did note an equivocal Spurling on the right and mildly positive on the left. There was evidence of myofascial findings in the bilateral upper trapezius levator scapulae, and splenius. The Claimant was then given Lidocaine injections.

The Claimant did not return to Dr. Spear until January 23, 2004. At that time, Dr. Spear reevaluated the Claimant and found no significant changes. The Claimant then received Lidocaine injections. He returned for more Lidocaine injections on March 19 and May 28, 2004.

On August 27, 2004, the Claimant presented to Dr. Spear complaining of discomfort around the elbow and proximal, but less into his hands. He also complained of right facial paresthesia. The physical examination revealed no significant changes. Dr. Spear noted evidence of primary myofascial findings in the right scalene, sternocleidomastoid, bilateral upper trapezius, and right levator. The Claimant underwent Lidocaine injections and Dr. Spear noted that the Claimant did feel improved directly after injections.

The Claimant returned on November 12, 2004. Dr. Spear ordered an MRI of the cervical spine. Upon physical examination, Dr. Spear noted that the Claimant had a mildly antalgic gait and had a minimal decrease in foot clearance. He also had some evidence of chronic atrophy in the bilateral gastroc-soleus complex, but there was no focal weakness. There was evidence of primary myofascial findings in the bilateral splenius cervicis, right levator scapulae, scalene, and sternocleidomastoid. The Claimant received Lidocaine injections. He also told Dr. Spear that he felt the injections were bringing him days to weeks of relief.

The results of the January 5, 2005 MRI are discussed above in Dr. Gurtner's records.

Medically Related Reports of Dr. Zarine Mistry (CX 5 and EX 5)

CX 5 and EX 5 contain medical record entries from Dr. Zarine Mistry at NDC Urgent Care. The Claimant saw Dr. Mistry on August 24, 1998, for treatment of a serum sickness reaction to a tetanus shot. Dr. Mistry also diagnosed the Claimant with hyperlipidemia and prescribed Lipitor.

The Claimant first saw Dr. Mistry for his May 27, 1999, injury on June 21, 1999. He complained of discomfort over the right side of his neck and shoulder. On examination, the Claimant had mild right trapezius muscular tenderness and palpation produced radicular pain and paresthesia of the right thumb. He was diagnosed with a cervical and right shoulder injury and radiculopathy. Dr. Mistry placed work restrictions of no climbing, limited use of right arm, and a weight lifting restriction of 10-15 pounds at that time.

The Claimant returned to NDC on June 26, 1999, for a recheck of radiculopathy. He continued to complain of paresthesia along the lateral forearm and thumb when palpating the right trapezius area. Upon examination, the Claimant's neck movements were full and intact, but full flexion and turning his head to the left caused paresthesia of his forearm and thumb. He was scheduled

for physical therapy three times a week for two weeks. At that visit, Dr. Mistry released the Claimant to return to regular work on June 28.

The Claimant went back to NDC on July 28, 1999, for a follow up. He complained of numbness in his index and long finger. Upon examination, he had tightness in the mid trapezius muscle. His neck had full range of motion and he had no evidence of muscle weakness or atrophy in the right upper extremity. His grip and reflexes were normal. He was ordered to continue physical therapy. (EX 5.)

On August 4, 1999, the Claimant presented to Dr. Mistry complaining of paresthesiae of his arm, forearm, and first three digits of his hand. Dr. Mistry noted that the Claimant had been treated with nonsteroidals, oral steroids, and four physical therapy sessions, with a 30% improvement in symptoms. On physical examination, Dr. Mistry noted that the Claimant's range of motion in his neck was full and intact. He also had slightly diminished sensation in his right thumb. He had no motor weakness and his reflexes were 1+. Dr. Mistry scheduled the Claimant for an MRI of the cervical spine.

On August 6, 1999, the Claimant underwent an MRI performed by Dr. Kothmann. The cervical vertebrae were found to be normal in height, alignment, and signal intensity, with reactive marrow endplate changes at C5/6. There was no abnormality in the cervical spinal cord and the craniocervical junction was normal. At C2/3, C4/5, and C7/T1, there were no abnormalities found. At C3/4, there was a very prominent osteophytic ridge posterolaterally on the left, resulting in narrowing of the left sided neural foramen. At C5/6, there was a small to moderate broad right sided disc protrusion with moderate to severe narrowing of the right sided neural foramen. At C6/7, there was a broad posterior osteophytic ridge/disc bulge asymmetric to the left with bilateral neural foraminal impingement, but no central canal stenosis. (CX 5.)

The Claimant returned on August 12, 1999, complaining that he could not go to work because of a stiff neck and headache. He stated his paresthesia was improving and he felt he was improving overall. Upon examination, he still had tenderness over the right supraspinatus. His shoulder movements were intact and he had no motor weakness of the upper extremities. He was told to continue physical therapy for two more weeks.

He returned on December 8, 1999, complaining of sharp pain in his neck after pulling a rope to start an air compressor. He stated he had been improving until the present day, when he had a recurrence of pain radiating down his right arm. On examination, his neck was supple and he had moderate tenderness over the right trapezius muscle. He had decreased sensation to the touch in his right thumb. There was no evidence of motor weakness. He was instructed to continue using moist heat and to wear his cervical collar at home. He was also given Celebrex and Vicodin.

The Claimant returned on April 1, 2000, complaining of increased cramping over the right side of his neck with radicular pain and paresthesia of his right thumb and index finger if he put pressure on the area. On examination, the Claimant had moderate tenderness in his neck and mild spasm over the right trapezius muscle. Lateral movement of his head caused radicular pain down to his thumb. He had subjective paresthesia, but there was no sensory loss or motor

weakness. He was told he could return to modified work duty with limited use of his right upper extremity and weight lifting was limited to 15 pounds. (EX 5.)

The Claimant saw Dr. Mistry again on January 25, 2001. He was complaining of right shoulder and right upper extremity pain. He also complained of mild pain in his left upper extremity. On examination, the Claimant's neck was tender, but movement was intact. He had no present radicular pain. Palpation of the supraspinatus area caused paresthesia of his right thumb and index finger. He had minimal sensory loss of his right thumb and there was no motor weakness of his thumb or fingers. There was no weakness of proximal muscles and his reflexes were symmetrical. Dr. Mistry gave the Claimant a cervical collar and prescriptions for Celebrex and Skelaxin.

On November 16, 2001, the Claimant went back to Dr. Mistry complaining of right shoulder pain and paresthesia in his right thumb and index finger. On examination, the Claimant's neck was supple and his movements were normal. Palpation of the right supraspinatus area reproduced radicular pain with parethesia along C6 distribution. He had no motor weakness and his reflexes were intact. Dr. Mistry placed the Claimant on light duty work with no climbing, limited use of right arm, and a weight restriction of 10-15 pounds.

Five days later, the Claimant returned, still complaining of right upper extremity pain and paresthesia of his right thumb and index finger. Nerve conduction studies performed the day before showed carpal tunnel syndrome with no evidence of cervical radiculopathy. Physical examination revealed supraspinatus tenderness which reproduced radicular pain with parethesia. The Claimant's sensation to touch and motor strength in his upper extremities was symmetrical and intact. Dr. Mistry stated that it was likely the Claimant was suffering from traumatic cervical radiculopathy and right carpal tunnel syndrome. Dr. Mistry directed the Claimant to stay on light duty.

The Claimant had an MRI of the cervical spine on November 28, 2001. Dr. Kothmann found the results to be similar to the previous MRI, with no significant interval changes.

On December 18, 2001, the Claimant had a radiological examination and C-spine to evaluate for instability. Dr. Scott Kellermeyer identified no instability. At C5/6 and C6/7, Dr. Kellermyerer observed disc space narrowing and ridging of the endplates of the vertebra. Also at C6/7, the Claimant had mild bilateral foramina narrowing. At C4/5, the Claimant had mild ridging with significantly less disc space narrowing. There were mildly prominent anterior osteophytes seen from C2 to C4. There was no evidence of acute fracture or subluxation at C2-T1. At C5/6 and C3/4, there also appeared to be mild foraminal encroachment.

Another MRI of the cervical spine was performed by Dr. Pinkston on December 22, 2003. Dr. Pinkston found no significant abnormalities at C2/3 and C7/T1. At C3/4, the Claimant had a left uncovertebral joint osteophyte with moderate left foraminal narrowing. At C4/5, there was a small bilateral uncovertebral joint osteophyte with mild bilateral foraminal narrowing. Degenerative disc disease was noted at C5/6 and C6/7 with mild to moderate bilateral foraminal narrowing at both levels. A disc protrusion at C6/7 was similar or slightly smaller than on the Claimant's prior study of June 24, 2003. (CX 5.)

Letters and Forms (CX 6, EX 7)

CX 6 contains twelve documents. The first document is the Employer's First Report of Injury or Occupational Illness, filed on January 30, 2001. The second is a letter from Crofton Diving containing a job description for the Claimant's job. The list of general duties included: planning jobs; loading equipment, much of which exceeded fifty pounds, for jobs; operating dive vessels; setting up dive stations; dressing divers; tending to the divers' umbilical slack, which may involve pulling weight against a current; and occasionally operating heavy equipment.

The third document is a letter from the District Director to the Employer's counsel. Document four was withdrawn from evidence, while documents five and ten contain correspondence between the Claimant's counsel and the Employer's counsel. In the letter dated September 21, 2005, the Employer's counsel notified the Claimant's counsel that the Claimant would be paid total disability through September 19, 2005. He stated that the Claimant would receive permanent partial disability compensation of $281.80 per week beginning September 20, 2005, based on a wage-earning capacity of $10.50 per hour. The sixth document is a letter from the claims examiner to the Claimant's counsel. Documents seven and eight are U.S. Department of Labor forms LS-208 and LS-206, which are also contained in EX 7. The LS-208 shows that the Claimant was paid temporary total disability benefits of $561.80 per week based on his average weekly wage of $842.70. The benefits began November 14, 2001, and were discontinued September 19, 2005, for a total of $112,841.54 paid. The LS-206 shows that the Claimant was paid $281.70 per week beginning on September 20, 2005, and continuing.

Records of GENEX Services (CX 6 and EX 3)

CX 6 and EX 3 both contain the results of the Claimant's Wide Range Achievement Test administered by Amy Bouchard on April 11, 2006, and Amy Lanman's Standards of Educational & Psychological Testing certificate. The Claimant scored at the fourth grade level for reading, the first grade level for spelling, and the third grade level for math.

Medically Related Reports of Dr. Martin V. Ton (CX 7)

CX 7 contains four medical record entries from Dr. Ton. The Claimant first saw Dr. Ton for a pain management consultation on January 21, 2002. He complained of sharp pain in his right arm and numbness in the first three digits of his right hand. He also complained of some weakness in his right hand. Upon examination, Dr. Ton determined the Claimant had no decreased sensation over his upper extremities. He did have hyporeflexive reflexes throughout his upper extremities which were trace biceps, triceps, and wrists. The Claimant had decreased grip strength in his right hand of 4/5. His range of motion in the right upper extremity was normal. During a cervical spine examination, Dr. Ton noted that the Claimant had full forward flexion and lateral rotation, but he had tightness to the right, which caused tightness in his neck. He did not have any radicular pain or numbness in his right hand, though. He also had spasm in the right trapezius. An EMG showed evidence of right median neuropathy, which is consistent with carpal tunnel syndrome. An MRI revealed a C5/6 right side neural foraminal stenosis due to osteophytes and a small posterolateral disc protrusion. There was also a broad posterior disc

bulge at C6/7. Dr. Ton diagnosed right cervical radiculopathy secondary to foraminal stenosis, with underlying carpal tunnel syndrome. He subsequently decided to give the Claimant a cervical epidural steroid injection.

The Claimant returned to Dr. Ton on February 5, 2002. He continued to complain of numbness and weakness in his right arm. Dr. Ton administered another cervical epidural steroid injection.

On February 21, 2002, the Claimant returned to Dr. Ton for a third epidural injection. He complained of right arm pain rated at a 4 out of 10, but stated that he had about a 30% improvement overall with the two prior injections.

Medically Related Report of Dr. B. Joe Ordonez (CX 8)

CX 8 contains one medical record entry from Dr. Ordonez. The Claimant went to Dr. Ordonez for a neurosurgical second opinion on August 6, 2003. He complained of continued neck pain with radiation into his shoulders, which persisted despite many conservative therapy treatments. He reported that his neck pain was worse with extension, which also caused numbness in his upper extremities. He also reported a burning sensation across his shoulders, a tingling associated with the arm numbness, and arm weakness, right greater than left. Upon physical examination, Dr. Ordonez noted decreased deltoid strength, and decreased bicep and tricep strength, all bilaterally, and decreased grip strength and decreased dorsal palmar interossei strength, both right worse than left. Sensory exam was decreased in his hands. Deep tendon reflex examination was increased in his upper extremities, except that it was decreased in his right biceps. Dr. Ordonez also reviewed the Claimant's recent MRI and EMG. He recommended the Claimant "undergo C5-6 and 6-7 anterior cervical discectomy followed by C5-6 and 6-7 arthrodesis using either left iliac crest bone graft or allograft followed by C5-7 anterior cervical instrumentation." Dr. Ordonez also told the Claimant that he felt his carpal tunnel syndrome could have been exacerbated by his fall.

Medically Related Reports of Dr. Ronald A. Stine (CX 9)

CX 9 contains six medical record entries from Dr. Stine. The Claimant first saw Dr. Stine on October 17, 2001, for a cardiac catheterization evaluation. He complained of intermittent slight discomfort in his chest, arm, neck, and sometimes into his throat, occasional shortness of breath, and occasional dizziness. Upon physical examination, Dr. Stine noted the Claimant had full range of motion in his neck, his lungs were clear, his heart was without murmur, gallop, click, or rub, and his abdomen was soft. His neurologic examination was described as within normal limits. Dr. Stine noted that the Claimant also had degenerative joint disease.

On November 1, 2001, the Claimant underwent left heart catheterization. Dr. Stine diagnosed moderate coronary artery disease. He recommended medical therapy and follow-up with evaluation of his cervical disc disease.

On May 15, 2002, the Claimant saw Dr. Stine for preoperative clearance for possible neck surgery. Dr. Stine determined that the Claimant had stable coronary artery disease, cervical radiculopathy, and Lipotor-induced muscle pain. He recommended a thallium stress test and

stated that if it was stable, the Claimant was cleared for surgery. The Claimant underwent a thallium stress test on May 23, 2002. He experienced chest pain, but it was interpreted as typical chest pain associated with IV adenosine. Dr. Stine found no diagnostic abnormalities.

On July 23, 2003, the Claimant was seen for a follow up and for a preoperative clearance for potential neck surgery. He denied any chest pain, shortness of breath, peripheral edema, PND, or orthopnea. He told Dr. Stine he was going to get a second opinion about the potential neck operation. Dr. Stine's impression was stable cardiovascular disease and he recommended another thallium stress test before clearing the Claimant for surgery.

Medically Related Reports of Dr. Jonathan W. Miller (CX 10, EX 5, and EX 6)

CX 10, EX 5, and EX 6 contain medical record entries from Dr. Miller, primarily related to treatment of the Claimant's anxiety, hyperventilation disorder, irritable bowel syndrome, diabetes, hypertension, hyperlipidemia, and coronary disease. On January 11, 1990, the Claimant saw Dr. Miller because of an acute anxiety attack one week prior. Dr. Miller noted the Claimant had been under a great deal of stress recently. On examination, the Claimant was nervous, pleasant, and in no acute distress. His blood pressure was 132/80. Dr. Miller scheduled a complete examination for one week later. (EX 5.)

The Claimant saw Dr. Miller for completion of the initial examination on January 18, 1990. The Claimant related a long history of neuropsychiatric disorder beginning in his 20s when he began taking Valium for irritable bowel syndrome. He took Valium for seven years. He told Dr. Miller that he was chronically nervous and irritable. He also stated that he sleeps well but frequently wakes up with anxiety symptoms. Dr. Miller diagnosed "clear cut anxiety and hyperventilation disorder." Dr. Miller also noted the Claimant was under a great deal of stress. Upon physical examination, the Claimant was 6'1 1/4" tall, weighed 228 pounds, and his blood pressure was 124/80. His neck was supple with no carotid bruits. Dr. Miller recommended that the Claimant continue therapy with respect to marital dysfunction and prescribed Tofranil for his anxiety disorder. The Claimant reported on February 12, 1990, that the Tofranil helped him sleep better and controlled his moods.

On May 26, 1994, the Claimant returned, complaining of more trouble with his anxiety and irritable bowel syndrome. He also complained of right back pain and right-sided abdominal pains, reflux problems, and chronic diarrhea. He described having mood changes with anxiety and having a short fuse during the day. He further described being under a lot of stress, always being "under the gun," and symptoms of hyperventilation. He stated he felt he was less under control. Dr. Miller stated the Claimant had clear cut anxiety disorder with hyperventilation and chronic sleep disorder. Upon physical examination, the Claimant was 6'2" tall, weighed 237 pounds, and his blood pressure was read first at 160/88 and then at 140/80. Dr. Miller observed that the Claimant was very talkative and anxious appearing. Dr. Miller stated that the Claimant had "really phenomenal anxiety" and sleep dysfunction, so he prescribed Tofranil again, which subsequently improved his anxiety.

The Claimant did not come back until March 15, 1996. He complained of about a month of recurrent left arm numbness and tingling that would sometimes wake him up at night and it also

occasionally occurred during the day. He also complained of emotional lability, facial flushing, and abdominal pain. He further described himself as being nervous and tense. Upon physical examination, the Claimant was 6'2" tall, weighed 232.5 pounds, and his blood pressure was 144/84. Based on test results, Dr. Miller suspected the Claimant had diabetes. Dr. Miller stated the Claimant's presenting symptoms could be related to his profound panic disorder; however, he ordered a thallium stress test to ease concerns of cardiac problems. He also prescribed Buspar to help with the Claimant's anxiety. The Claimant reported on March 28, 1996, that the Buspar helped him feel calmer. (CX 10.)

On February 26, 1997, the Claimant went to Dr. Miller complaining of flank pain and bilateral lower quadrant pain. Upon examination, the Claimant had no muscle tenderness and had good reflexes and normal strength. His blood pressure was 150/80 and he was very nervous and anxious. Dr. Miller stated he had multifocal symptoms that were clearly related to his anxiety. Dr. Miller prescribed Tofranil again, which the Claimant later reported helped him sleep better.

In August 1998, the Claimant suffered a finger laceration and was given a tetanus shot, which caused him to suffer a serum sickness reaction. The Claimant saw Dr. Miller three times from August to October 1998 for treatment of the reaction, which had caused joint pain and a large effusion in his left knee. Dr. Miller ordered an x-ray of the Claimant's left knee, which revealed mild narrowing of the patellofemoral joint compartment. Dr. Miller stated that, clinically, it appeared that the Claimant had persistent arthritis.

The Claimant saw Dr. Miller on June 15, 1999, complaining of tingling, tenderness, and some pain above his right shoulder and into his neck related to a fall on May 27, 1999. He stated that when he pressed hard on the tender area, he noticed tingling in the C5 dermatome lateral aspect of the shoulder radiating down into his thumb. Upon examination, his shoulder range of motion was unimpaired and his neck range of motion was unimpaired, but he did have a little tingling in his arm with right side flexion. His resisted motions were painless and his strength was good. Dr. Miller did not find much to suggest brachial plexopathy or cervical radiculopathy on clinical examination. Dr. Miller suggested neck and shoulder x-rays and he gave the Claimant Naprosyn. The x-ray was performed the same day and showed no fracture or destructive lesion. His shoulder was normally aligned. There was straightening of the cervical lordosis, which could have been positional or a muscle strain. Degenerative changes were noted at C5/6 and C3/4. (EX 5.)

Between June 22, 2001 and December 4, 2001, the Claimant returned to Dr. Miller seven times. He complained of anxiety, depression, "not feeling like himself," irritability, disabling neck discomfort, and radicular discomfort. In that time, the Claimant's weight fluctuated between 223 pounds and 231 pounds and his blood pressure fluctuated, but Dr. Miller stated that the Claimant was not hypertensive. Dr. Miller diagnosed anxiety attacks with intermittent near panic-type attacks and mild depression. He prescribed Zoloft and suggested psychiatric counseling. Dr. Miller also stated he would address the Claimant's other medical complaints if he remained compliant in following up.

The Claimant returned on April 3, 2002 complaining of neck and arm pain and anxiety attacks. Upon examination, the Claimant weighed 234 pounds, his blood pressure was 140/84, and his

diabetes was poorly controlled. Dr. Miller treated the Claimant for diabetes and noted the Claimant had been seeing Dr. Koen and Dr. Ton for his pain. A follow up was scheduled in four months.

The Claimant went for his follow up on August 22, 2002. Since the last visit, he had had cervical decompression with improvement in his right-sided radiculopathy. Dr. Miller also noted an improvement in his agitation level. The Claimant complained of flushing from Niaspan prescribed by Dr. Stine. On examination, the Claimant had gained one pound since his prior visit and his blood pressure was 140/80. Dr. Miller instructed the Claimant to advise of his Niaspan dose so it could be adjusted. A follow up was scheduled in three months. At his follow up on November 20, 2002, the Claimant complained of muscle aches and flushing, which was attributed to his medication. He was examined and found to be 236 pounds, his blood pressure was 146/80, and he was in no acute distress. He was treated and told to return in three months.

On January 9, 2003, the Claimant presented to Dr. Miller complaining of elevated blood sugar, Bell's palsy, and a feeling of weakness. Upon examination, Dr. Miller noted that the Claimant's blood pressure was 134/72 and he was "his usual anxious self." Dr. Miller treated the Claimant for Bell's palsy and diabetes and instructed him to return in one month.

The Claimant returned for his follow up on February 25, 2003 complaining about his neck pain, which Dr. Miller noted was being treated by other physicians. Upon examination, the Claimant's blood pressure was 138/82 and Dr. Miller found him to be agitated and anxious. Dr. Miller treated the Claimant's hyperlipidemia and told him to follow up in three months.

When the Claimant returned on May 27, 2003, he complained of neck, shoulder, and arm pain. Upon examination, Dr. Miller found the Claimant to be gregarious and anxious, but in no acute distress. His blood pressure as 130/76 and his diabetes continued to be poorly controlled. Dr. Miller treated the Claimant's diabetes and stated that there was not much he could do until the Claimant got his neck problems resolved.

The Claimant went back to Dr. Miller on August 25, 2003 and continued to focus on and complain about the chronic pain in his neck. Upon examination, the Claimant was plethoric, obese, very anxious, and his blood pressure was elevated to 162/74 upon first reading and 154/80 upon second reading, which Dr. Miller attributed to the Claimant's anxiety. His diabetes was well-controlled. (CX 10.)

On November 11, 2003, the Claimant saw Dr. Miller. He complained of right leg pain and distal parasthesias. He also complained about his neck problems and the consultations he had with different neurosurgeons. On examination, he was gregarious and in no acute distress. He weighed 234.5 pounds, his blood pressure was 154/90, and had mild flushing of his skin. Dr. Miller noted the Claimant's diabetes control was suboptimal. Dr. Miller ordered a nerve conduction study, which was performed on November 13. The impression was an abnormal NCS/EMG with evidence of sensory neuropathy. There was no evidence of radiculopathy. The Claimant returned to Dr. Miller on December 2, 2003, for a follow up and the nerve conduction and Dr. Miller assured the Claimant his leg problems were unrelated to his neck problems. The Claimant's blood pressure was 134/78, and Dr. Miller opined that the Claimant's diabetes and

blood pressure were adequately controlled. Dr. Miller noted the Claimant's neck problems were dominating his life at this time. (EX 6.)

On December 19, 2005, the Claimant complained that he was not sleeping, was having a lot of neck pain, was having trouble coping, and was getting depressed. He stated that his sleep was interrupted by his head falling off the pillow followed by acute mechanical neck pain and radicular pain. Dr. Miller prescribed Trazodone and Zoloft. (CX 10.)

Testing Reports of Barbara K. Byers (CX 11)

CX 11 contains the results of the Woodcock-McGrew-Werder Mini-Battery of Achievement testing conducted Barbara K. Byers. Both Basic Skills and Factual Knowledge were tested. The Basic Skills score is based on reading, writing, and mathematics skills, while the Factual Knowledge score is based on science, social studies, and humanities skills. When compared to others at his age level, the Claimant's Basic Skills score was in the low average range. He was average in mathematics, low average in reading, and low in writing. His Factual Knowledge score was average. When compared to others at his grade level, the Claimant's Basic Skills score was low. He was low average in reading and mathematics and very low in writing. His Factual Knowledge score was average.

Deposition of Dr. Petra Gurtner (CX 12)

Dr. Gurtner was deposed on June 15, 2006. On direct examination, she testified that she had been a board certified neurosurgeon since 1995 and that she had practiced in the community since April of 1998. She had also been a resident at Eastern Virginia Medical School between 1986 and 1991. Dr. Gurtner's curriculum vitae was marked as Exhibit 1.

Dr. Gurtner testified that she had seen the Claimant on January 6, 2004, and he told her about the May 27, 1999, accident. He said he was walking backward when he tripped and fell on his outstretched right hand. He told her he immediately felt limp in all four extremities and had severe right upper extremity pain. The Claimant stated that he initially saw Dr. Mistry, who diagnosed him with cervical radiculopathy. He then went to Dr. Rashti and Dr. Koen, who evaluated him. Dr. Koen later performed a right-sided C5/6 posterior decompression of the neuron foramen. The Claimant did not have much improvement after the surgery in 2002. She stated that it was recommended to have an anterior approach to correct the C5/6 and C6/7, but he was unsure, so he obtained a second opinion from Dr. Ordonez, who concurred. The Claimant then came to Dr. Gurtner for a third opinion.

When the Claimant presented to her, Dr. Gurtner testified that he complained of ongoing severe neck pain and a sharp pain between his shoulder blades that was worse when he tried to lift or pull anything. He also complained of numbness in the first three digits of both hands and occasional weakness and shakiness in both hands. She reported that, upon physical examination, the Claimant had no obvious fasciculations or atrophy, but he did have palpable muscle spasm in the right cervical and upper thoracic region. Dr. Gurtner stated that she did not think he would benefit from surgery presently, and suggested conservative treatment instead.

Dr. Gurtner reported that, approximately one year later, the Claimant returned. He had not improved much in the interim. He continued to complain about numbness in the first three digits of both hands, his hands were still weak, and he had virtually no grip. He was also having more trouble with his lower extremities and now complained of numbness in the first three toes of his left foot. At that time, Dr. Gurtner had the Claimant get another MRI, which was essentially unchanged from the prior year and showed foraminal narrowing on the right at C5/6 and disc disease at C6/7 more on the left than the right. When asked about whether the Claimant had sleeping problems, Dr. Gurtner stated that the Claimant told her he could only sleep with several pillows propped under his head and he could not straighten his neck at all. Dr. Gurtner testified that she offered the Claimant surgery at that visit because of his increased neck stiffness and left bicep and tricep weakness, but she told him the surgery could not be performed unless he got his blood sugar more under control.

Dr. Gurtner testified that, in a June 22, 2005, letter to the Claimant's counsel, she stated that the Claimant was unable to tolerate a stressful work environment because of his diabetes, coronary artery disease, and hypertension. She also testified that the Claimant's chronic pain was a stress on all his medical conditions and she thought it sometimes exacerbated his diabetes and hypertension.

Dr. Gurtner stated that the Claimant returned to her on October 6, 2005, because of increased neck pain, weakness of both hands, and weakness of the left foot and sciatica. She also stated that he appeared quite depressed and that he had quit taking all his medications. She testified that she felt his chronic pain caused his depression, that these things combined made him act more irrational, and that he was not paying proper attention to his medical conditions. Dr. Gurtner further testified that she called Dr. Miller because the Claimant had quit all his medications and had a very high blood pressure reading of 180/120. She then stated that, in her opinion, the Claimant's findings were suggestive of depression and possibly progression of cervical stenosis. She renewed his prescriptions and asked him to take an antidepressant and see Dr. Doyle, a psychiatrist, for chronic pain and depression.

Dr. Gurtner related that she had sent a letter to Roslyn Weinstein on October 18, 2005, in which she opined that she could no longer approve the jobs of dispatcher, police telecommunicator, contact lens technician/inspector, small parts assembler, travel counselor, service representative, lot attendant/valet, or unarmed security guard because of the Claimant's work history, education, and examination of October 6, 2005. She stated that she felt he could not handle the stress of certain jobs and could not handle instructions because of his medical conditions and depression. She also stated that, in her opinion, he was medically incapable of carrying out any jobs as of October 2005, and that condition continued to date.

Dr. Gurtner testified that on October 26, 2005, she told the Claimant she would set him up for surgery once his depression lifted and he was medically stable. She stated that, when he returned on April 20, 2006, he complained of severe neck spasms and pain in both upper extremities, more on the left than right. He also complained of left-sided sciatica and involuntary muscle twitches in his legs. She stated he had been advised by Dr. Ward to proceed with surgery, but she still found him to be too depressed and unable to handle additional stress. At this visit, Dr. Gurtner related, the Claimant could not extend his neck, he had severe limited range of motion in

his neck, and he could not lie flat. He had to have pillows propping him up to tolerate the pain. She stated that she had observed spontaneous myoclonus and fasciculations in both lower extremities, he had weakness in his left biceps and triceps, and his grip was four out of five in both hands. Additionally, he had decreased sensation in the first two digits of his right hand, decreased strength in both lower extremities, a positive Laseuge on the right, his gait was ataxic, and his deep tendon reflexes were increased. He had evidence of peripheral neuropathy, so she repeated his MRI. She also found him to be extremely depressed and angry. She testified that she ordered aquatherapy three times per week for sixteen weeks to help loosen the muscle spasms in the Claimant's neck

Dr. Gurtner reported that she last saw the Claimant on May 16, 2006. At that time, he complained of numbness on the left side of his face, but the rest of his examination remained essentially unchanged. She told the Claimant that, before she would operate on his neck, he had to get a brain MRI to rule out multiple strokes or another problem. Dr. Gurtner testified that, if the Claimant refused surgery, he has reached maximum medical improvement.

On cross-examination, Dr. Gurtner testified that, when she evaluated the 2003, 2005, and 2006 cervical MRIs, there was little change from the first to the most recent, even though the Claimant's examination continued to get worse. She stated that she thought this was because he was having tremendous muscle spasms from his chronic pain and he could not relax his paraspinal muscles, so he had severe pain syndrome, which in turn reduced his strength. She also stated that she suspected small vessel disease, based on the Claimant's gait ataxia and loss of position sense. She testified that these are signs of injury to the spinal cord or brain, which she attributed to his work as a diver and could be compounded by hypertension and diabetes.

Dr. Gurtner stated she was aware that Dr. Miller was the Claimant's family doctor, but she had not known the length of time he had been treating the Claimant. She did not think she had any medical records from Dr. Miller, but she had talked to him on the telephone regarding the Claimant. She testified that she had been aware the Claimant was diagnosed and treated for diabetes, high blood pressure, and cardiac problems. According to Dr. Gurtner, high blood pressure, diabetes, and stress are risk factors for developing heart problems. She opined that the Claimant's diabetes may have contributed to his pain and reduced his ability to heal injured nerves.

Dr. Gurtner explained that she was concerned the Claimant was suffering from strokes because divers can have micro embolisms into parts of the brain and spinal cord when they ascend, which is called the bends. She went on to say that typical diving injuries include those to the deep structures of the brain and the core of the spinal cord, which usually manifest themselves right away. However, even when divers look fully recovered on the outside, those who have been diving for years typically have significant deficits in cognition and movement.

She indicated that she was aware that Dr. Miller had treated the Claimant for chronic anxiety disorder and depression, but she did not know when the depression and anxiety started or for how long Dr. Miller had treated the Claimant. She stated that when a condition is chronic, is it not exactly permanent, but it has been present for more than six months. Dr. Gurtner further stated that the drugs Tofranil, Valium, and Buspar were use to treat anxiety. She reported that

she diagnosed the Claimant with depression because he had abandoned medical treatment, he was extremely aggravated and agitated, and he was aggressive toward both Dr. Gurtner and his wife. She also reported that the Claimant had become less pleasant in their recent encounters than he was the first time he saw her. She subsequently sent him to a psychologist to confirm her diagnosis. Dr. Gurtner testified that she would not recommend surgery until the Claimant's depression was controlled and his other medical conditions were evaluated and under control.

When asked whether the Claimant would be able to work in some capacity if he did not have any of his present medical and psychological conditions, but still had the neck problems from his work injury, Dr. Gurtner testified that the Claimant probably would be working. She stated that her opinion that he should not be working now was based on all the Claimant's medical and psychological conditions as well as his neck injury. In Dr. Gurtner's opinion, if the Claimant had successful neck surgery now, his other medical conditions, depression, and cognitive problems would still not be resolved and this would prohibit him from obtaining any kind of employment. She also stated that the restrictions she had placed on him would go up to twenty pounds lifting and pulling if the Claimant had no other medical, psychological, or cognitive problems and had successful neck surgery.

Dr. Gurtner stated that she did not think the Claimant needed a functional capacity evaluation in 2005 when one was suggested. She felt that the restrictions of no overhead lifting and lifting no more than ten pounds would limit any kind of functional capacity evaluation. Further, she stated that he was so aggravated and depressed that he would not follow instructions anymore. She also stated that many times when she talked to the Claimant, his face would get red, which she attributed to high blood pressure.

On October 18, 2005, Dr. Gurtner testified, she disapproved the jobs of dispatcher, police telecommunicator, contact lens technician/inspector, small parts assembler, travel counselor, service representative, lot attendant/valet, and unarmed security guard. However, she testified that she did not indicate anywhere in that letter or any other written communication that he could not work at all. She indicated that in all spoken communication with the Claimant after that date, she advised him not to go back to work, but she always set him up for a second opinion or more physical therapy.

Dr. Gurtner was shown an x-ray from March 15, 1996, a copy of which is contained in EX 5. She stated the x-ray showed evidence of ossification of the anterior longitudinal ligament involving the mid and lower portions of the thoracic spine, which is consistent with ankylosing vertebral hyperostosis, but it was not as apparent on the recent MRI. She testified that ankylosing vertebral hyperostosis is a bony arthritic change of the joints that stiffens all the joints. She reported that many people who have this condition cannot straighten their heads anymore and cannot walk well because of the kyphotic deformity. However, even though the Claimant cannot straighten his head very well and cannot do much, her opinion was that he did not have full-blown ankylosing vertebral hyperostosis. She stated that the condition gets worse over time and can be diagnosed as a genetic disorder, although she was unaware if the Claimant had had these tests.

Dr. Gurtner reported that she had seen an EMG from November 13, 2003, which showed abnormal nerve conduction of the lower extremities, consistent with sensory neuropathy. There was no indication of radiculopathy in the lumbar. Dr. Gurtner opined that the abnormal EMG could be caused by complications from diabetes, but there could be other explanations as well.

Dr. Gurtner also discussed the Claimant's lumbar MRI and stated that it is not unusual to see changes and protrusion in a 66-year-old's spine without having traumatic injury. She further stated that people who are not divers have degenerative changes in their lumbar spine.

On redirect examination, Dr. Gurtner testified that, starting in October of 2005, she told the Claimant she did not expect any more useful employment from him. She stated she did not put it in writing, but thought she may have once answered a job search in that manner.

Functional Capacity Evaluation from Sports Therapy and Industrial Medicine Center (EX 2)

EX 2 is the report from the Claimant's Functional Capacity Evaluation, which was performed April 21-22, 2003, by Andrea Powell and Peter Owen. The Claimant presented with a forward head posture with anterior rounded shoulders and slight thoracic kyphosis. The Claimant reported chronic neck and shoulder pain and variable radiculopathy into the right greater than left upper extremities. He also reported that he participates in only light daily activities with some walking. He put forth an acceptable effort in performing tasks, but he appeared very frustrated and anxious that he could not perform better. During forceful exertion or where co-contractions of the upper back or neck were involved, the Claimant limited himself.

Physically, the Claimant's cervical spine range of motion was as follows: flexion 75%, extension 0%, side flexion 10% bilaterally, rotation left 25%, right 50%. His thoracic flexion was within normal levels, with fixed kyphosis limiting extension. His lumbar range of motion was within functional levels. Shoulder flexion and abduction were limited to 100 degrees because of arm symptoms and lack of thoracic extension. His general grip strength values were in the low percentile. General fatigue and a deconditioning response were noted after he walked approximately five minutes at 1.0 miles per hour, normal gait maintained. He could stay in a static position for a projected range of fifteen to twenty minutes, specifically when operating a vehicle because the postural demand and outstretched extremity weight would induce symptom response patterns.

On the Physical Capacities Form, it was noted that the Claimant's weight capacity was restricted to ten pounds for most activities, and was only recommended for 6-33% of an 8-10 hour work day. His flexibility positions, including elevated work, forward bending/sitting and standing, twisting, crawling, kneeling, stooping, and squatting, were limited to 1-33% of the work day. His sitting tolerance was 67-100% of the work day, but intermittent with vehicle operation and his standing tolerance was 34-66% of the work day. Walking was limited to 6-33% of the work day, while stair and ladder climbing were limited to 1-5% of the work day. The Claimant was recommended to resume his medically directed walking program for secondary health reasons and for general endurance.

The Claimant was determined to be "functioning at a SEDENTARY physical demand safely and productively while maintaining good neutral truck positions and avoiding end range reach patterns of any resistance or duration. He does not demonstrate the ability to effectively meet the critical demands of his customary employment relative to job side location, work environment, and potential for heavier forceful exertion and climbing."

Records of Atlantic Vocational Services (EX 4)

EX 4 contains the records of Barbara K. Byers regarding vocational evaluation and job placement services for the Claimant. On March 30, 2005, Ms. Byers sent a letter to the Claimant scheduling him for an appointment on April 5, 2005. Ms. Byers received a letter from the Claimant's counsel stating that the Claimant would not be meeting with her. On April 20, 2005, Ms. Byers sent the Claimant a list of four job openings he would qualify for: travel counselor, lab technician, dispatch call taker, and dispatcher trainee. Nine days later, she sent another letter to the Claimant identifying two more open positions: gate guard/security and emergency coordinator. Three days after that letter, Ms. Byers sent another letter identifying four more positions: service valet, two dispatcher positions, and light manufacturing.

Ms. Byers completed a labor market survey report on May 17, 2005, without the benefit of meeting with the Claimant because of the refusal of his counsel. She reviewed Dr. Gurtner's medical records and the records of FARA Healthcare Management. She used the *Dictionary of Occupational Titles*, *Occupational Handbook*, the U.S. Department of Labor, Bureau of Labor Statistics, and information from the Virginia Employment Commission. She also contacted local area employers for job information. Ms. Byers identified jobs for the Claimant based on his age, work, history, and physical capabilities, taking into consideration Dr. Gurtner's restrictions of light duty work with no lifting over ten pounds, no pulling over ten pounds, no overhead work, and no repetitive bending. These jobs were the ten previously identified positions communicated to the Claimant in Ms. Byers's letters of April 20, April 29, and May 2. Ms. Byers sent the list of jobs to the Claimant and sent detailed job descriptions to Dr. Gurtner for review and approval. On July 29, 2005, Dr. Gurtner approved the jobs descriptions of dispatcher, police telecommunciator, contact lens lab technician/inspector, small parts assembler, travel counselor/service representative, lot attendant/valet, and unarmed security guard after reviewing the job descriptions.

On May 18, 2005, Ms. Byers sent follow up letters to the employers identified in the labor market survey asking them if the Claimant had contacted them regarding their job openings. Reliance, City of Chesapeake, CTR Group, the Virginia State Police, East Coast Appliance, and Greenbriar Volkswagen responded that the Claimant had not submitted an application. In a June 17, 2005, letter to Andrea Webb, Ms. Byers stated that Manpower also did not have an application from Claimant and two employers did not respond.

On May 3, 2006, Ms. Byers sent a letter to the Claimant's counsel stating that she had scheduled the Claimant for a vocational evaluation on May 9, 2006, pursuant to a Motion to Compel. On May 22, 2006, Ms. Byers completed a labor market survey report based on her vocational evaluation interview with the Claimant and his medical records. As with the 2005 market survey, she used the *Dictionary of Occupational Titles*, *Occupational Handbook*, the U.S.

Department of Labor, Bureau of Labor Statistics, and information from the Virginia Employment Commission and contacted local area employers for job information.

During the interview, Ms. Byers noted the Claimant's physical medical background, his subjective complaints, social and educational background, work history, vocational testing results, vocational assets, and current restrictions. Ms. Byers summarized the Claimant's medical background from the medical records she reviewed. Subjectively, the Claimant reported that he sometimes has numbness in his toes and tingling in the first three digits of each hand. He told Ms. Byers he believed his grip had decreased. He stated he is able to sit for less than one hour, is limited in how long he can stand, and can walk one block. He does not bend, kneel, or lift. He stated he does drive, but uses the mirrors instead of turning his head. He complained that he has shortness of breath from exertion, has difficulties climbing stairs, and cannot climb a ladder. He also complained of low back pain. He did say that he has no limitations on hearing or talking.

Ms. Byers noted that the Claimant attended school until seventh grade. He told Ms. Byers he was expelled at that time for fighting. He then went to work with his father on a fishing trawler and did construction and heavy equipment operation. In 1960, he started working as a diver for Crofton Diving. He did underwater construction and repair work. After 21 years, he became a dive supervisor, which involved supervising and training divers, interacting with military and civilian customers, monitoring air gauges, and ensuring the divers' safety. He dictated a diving log to a subordinate to write. He worked there until 2000.

With respect to vocational testing, Ms. Byers noted that Amy Bouchard had administered a Wide Range Achievement Test on April 11, 2006. The Claimant's grade equivalent scores were quite low, but Ms. Byers stated that the proper measure of performance for that test was the standard score, which allows comparison with the age appropriate normative group. She stated the average standard score is 100 with a standard deviation of 10 points, making any score between 90 and 110 average. The Claimant's reading word recognition score of 81 and arithmetic score of 83 were in the low average range, while his spelling score was 69 and well below average. On May 9, 2006, Ms. Byers administered the Wookcock-McGrew-Werder Mini Battery of Achievement. The Claimant's reading score of 85 and mathematics score of 83 were in the low average range, while his writing score was 63 and well below average. His factual knowledge score was 98 and in the average range.

Ms. Byers stated that the Claimant made an excellent appearance and was well spoken. She concluded he was of average intelligence and had an excellent work history. She noted that his skills included supervising, dealing with people, and structural repair. His current work restrictions, imposed by Dr. Gurtner, were no lifting/pulling beyond ten pounds and no overhead work or repetitive bending. Based on all the above. Ms. Byers identified eleven jobs for which the Claimant would be qualified, none of which required a high school diploma or GED. These included lot attendant, cashier, cashier/museum guide, unarmed security guard, driver, parking cashier, cashier/sales associate, and toll collector. All positions involved either lifting less than ten pounds or no lifting at all. The two unarmed security guard positions involved walking and standing, and one specified that no apprehension would be involved. The two lot attendant positions and two unarmed security guard positions required a valid drivers' license. The

employers offering the two cashier positions, the cashier/museum guide position, and cashier/sales associate position indicated they would train new employees.

Medically Related Records of NDC Medical Center (EX 5)

EX 5 contains medical record entries from NDC Medical Center and Urgent Care, starting from September 25, 1985. Since that time, Claimant visited NDC multiple times for various illnesses, including urinary tract infections and serum sickness from a tetanus shot in 1998, which caused arm, leg, and joint pain. The Claimant also went to be treated for the May 27, 1999, injury. Those records are discussed in the medical reports of Dr. Mistry, *supra*.

Employer's 8(f) Application (EX 8)

EX 8 contains the Employer's application for 8(f) relief filed June 22, 2005. Medical records from the Claimant's treating physicians were attached. A medical report, dated April 19, 2000, from Dr. Robert Rashti was also attached. The Claimant was referred to Dr. Rashti by Dr. Mistry. Dr. Rashti examined the Claimant on April 10, 2000. At that time, the Claimant complained of neck and right trapezius pain, right arm pain and paresthesias, and headaches. Upon examination, the Claimant's neurological exam revealed good strength in the major muscle groups of the upper extremities. His reflexes were 1+ and symmetric and his sensory examination was intact to light touch and pin sensation. He had bilateral Tinel's signs at the wrist. Dr. Rashti diagnosed acute degenerative cervical spine disease, secondary muscle ligametous strain, and right carpal tunnel syndrome. He prescribed Anaprox, Xanax, and Tylenol 3.

DISCUSSION

The parties have stipulated that the Claimant suffered a compensable injury while in the course and scope of his employment on May 27, 1999, that the parties are subject to the Act, that the Employer received timely notice of the injury, and that the Claimant cannot return to his pre-injury employment. The Parties are also not disputing any entitlements under the Act which may have existed prior to April 16, 2003. Therefore, this Decision and Order addresses only that period commencing April 16, 2003.

The Act defines "disability" as "incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10) (2000). There must be an economic loss coupled with a medical (physical and/or psychological) impairment. *Sproull v Stevedoring Services of America*, 25 BRBS 100 (1991)

A disability is classified, at various times, as either "temporary" or "permanent." *See* 33 U.S.C. § 908. An employee's injury becomes "permanent" when the employee's medical impairment either (1) reaches the point of maximum medical improvement, or (2) has continued for a lengthy period of time and appears to be of lasting or indefinite duration. *James v. Pate Stevedoring Co*., 22 BRBS 271 (1989); *Watson v. Gulf Stevedore Corp*., 400 F.2d 649 (5th Cir. 1968), *cert. denied*, 394 US 976 (1969); *Newport News Shipbuilding and Dry Dock Co. v. Director, OWCP (Chappell)*, 592 F.2d 762, 764, 10 BRBS 81, 83 (4th Cir. 1979) (quoting *Watson v. Gulf*

Stevedore Corp., 400 F.2d 649, 654 (5th Cir. 1968)). If neither of these tests are met, the claimant is "temporarily" disabled, rather than "permanently" disabled. The point at which an employee's medical impairment moves from "temporary" to "permanent" status is based on the medical evidence. Economic or vocational factors are not relevant to the determination of permanency. *Ballesteros v. Willamette Western Corp*., 20 BRBS 184 (1988) Generally, where further surgery is anticipated, permanency is not demonstrated. *Dorsey v. Cooper Stevedoring Co*., 18 BRBS (1986), *pet. dismissed sub nom*. *Cooper Stevedoring Co. v. Director, OWCP*, 826 F.2d 1011 (11th Cir. 1987); *Kuhn v. Associated Press*, 16 BRBS 46 (1983) However, the mere possibility of surgery or the uncertainty of the ability to do any work after surgery do not preclude a finding of "permanent" status. *Worthington v. Newport News Shipbuilding and Drydock Co.*, 18 BRBS 200 (1986); *Philips v. Marine Concrete Structures*, 21 BRBS 233 (1988); *White v. Exxon Co*., 9 BRBS 138 (1978), aff'd 617 F.2d 292 (5th Cir. 1980)

The disability is also classified, at various times, as either "partial" or "total." *See* 33 U.S.C. § 908 (2000). To be awarded disability benefits, a claimant must first demonstrate his inability to return to his former job because of his work-related injury. *See v. Washington Metropolitan Area Transit Authority*, 36 F.3d 375, 380 (4th Cir. 1994). Once the claimant has proven he cannot return to his former position, the burden shifts to the employer to show the availability of suitable alternative employment for the claimant. *Id.*; *Chappell*, 592 F.2d at 765. In identifying suitable alternative employment, the claimant's "age, background, employment history and experience, and intellectual and physical capacities" must be taken into account. *Trans-State Dredging v. Benefits Review Board*, 731 F.2d 199, 201 (4th Cir. 1984) (quoting *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1042-43 (5th Cir. 1981)). A single job opening will not satisfy the employer's burden; "an employer must present evidence that a range of jobs exists" that the claimant can perform and realistically secure. *Lentz v. Cottman Co.*, 852 F.2d 129, 131 (4th Cir. 1988). Further, these jobs must be "reasonably available in the community for which the claimant is able to compete and which he could realistically and likely secure." *Trans-State Dredging*, 731 F.2d at 201 (quoting *Turner*, 661 F.2d at 1042-43). If the employer fails to establish that suitable alternate employment exists, the claimant's disability is considered to be "total." If suitable alternate employment exists, the disability would be classified as "partial" if the suitable alternate employment did not provide the claimant at least the same income realized by the claimant in the pre-injury employment position.

For a job opportunity to be realistically available, all pre-existing limitations, both physical and psychological, must have been considered along with restrictions stemming from the work-related injury. *See Tartan Terminals, Inc. v. Puller*, 175 F.3d 1016, (4th Cir. 1999) (unpublished table decision) (holding that all the claimant's limitations must be considered); *White v. Peterson Boat Co.*, 29 BRBS 1, 13 (1995) (stating that pre-existing psychological problems should be addressed); *Fox v. West State, Inc.*, 31 BRBS 118, 121 (1997) (stating that "pre-existing limitations must be addressed in determining whether a job is realistically available"). Additionally, the precise nature and terms of each job must be established. *Rieche v. Tracor Marine, Inc.*, 16 BRBS 272, 274 (1984). The pay scale for the positions must also be established, so as to show the claimant's earning capacity. *Moore v. Newport News Shipbuilding & Dry Dock Co.*, 7 BRBS 1024, 1027 (1978) (quoting *DuPuis v. Teledyne Sewart Seacraft*, 5 BRBS 628, 630 (1977)). However, the employer is not required to contact a prospective employer to see if that employer would hire someone with the claimant's characteristics. *Trans-*

State Dredging, 731 F.2d at 201. Additionally, the employer does not have to contact prospective employers for specific job requirements; standard occupational descriptions may be relied upon to determine the necessary qualifications and requirements. *Universal Maritime Corp. v. Moore*, 126 F.3d 256, 31 BRBS 119, 125 (CRT) (4th Cir. 1997).

I. Claimant's Medical Condition as a "Temporary" verses "Permanent" Disability since April 16, 2003.

A. Medical Background Related to the Period Prior to April 16, 2003

The Claimant sustained a work injury to his neck and upper right extremity on May 27, 1999. The diagnosis was right cervical body C6 radiculopathy and right carpal tunnel syndrome. Dr. Mistry treated the Claimant and placed work restrictions on him prohibiting climbing activities, lifting more than 10 to 15 pounds, limited turning of the head to the right and limited use of the right arm. Dr. Mistry prescribed physical therapy and released the Claimant back to work the end of June 1999. An August 6, 1999, cervical MRI revealed a left-side ridge at C3/4, a protrusion and narrowing on the right-side of C5/6, and a ridge and disc bulge at C6/7. Various medications, physical therapy and cervical collar were prescribed into 2001. Through November 2001 Dr. Mistry continued to diagnose cervical radiculopathy and right carpal tunnel syndrome and continued the original work restrictions. On October 17, 2001, the Claimant was seen by Dr. Stein for cardiac evaluation. A left heart catheterization was performed on November 1, 2001 which led to a diagnosis of moderate coronary artery disease to be treated by medical therapy. Dr. Stein recommended follow-up evaluation of the cervical disc disease.

On December 17, 2001, the Claimant began treatment with Dr. Koen for right-side C6 radiculopathy and right-side carpal tunnel syndrome. The Claimant received three pain management treatments from Dr. Ton in January and February 2002. Subsequently, Dr. Koen recommended neck surgery on May 1, 2002. Dr. Stein cleared the Claimant for surgery after a thallium stress test on May 28, 2002. On July 26, 2002, Dr. Koen performed a posterior foraminotomy over the right C6 nerve root. Post surgical recovery was followed by prescribed medication and physical therapy. On December 11, 2002, Dr. Koen opined that further surgery would not provide any additional benefit to the Claimant and referred the Claimant to Dr. Spear for pain management.

On January 8, 2003, Dr. Spear began injection treatments for pain management. On January 15, 2003, Dr. Spear directed the Claimant not to work. The injections were approximately every two weeks through April 2, 2003. The Claimant reported at the February 5, 2003, appointment for injections that he experienced increased pain when opening a heavy door. At the April 2, 2003, appointment he reported increased pain after raking leaves the day before. On April 16, 2003, Dr. Spear opined that the Claimant had "reached a state of plateau with regards to further physical therapy efforts … [and] reached maximum medical improvement from a physiatric standpoint" (CX 4 and EX 1) and recommended a functional capacity evaluation prior to returning to his neurosurgeon, Dr. Koen. A January 18, 2003, entry notes that the Claimant's recent bout with Bell's Palsy had resolved.

It is noted that Dr. Miller was the Claimant's family physician and had treated the Claimant in January 1990 for reported anxiety and hyperventilation. The Claimant saw Dr. Miller again for the same complaint in May 1994 and for anxiety symptoms in March 1996 and February 1997. During the August to October 1998 timeframe, the Claimant was treated for an allergic reaction to a tetanus shot. The Claimant saw Dr. Miller seven times between June 2001 and December 2001 mild depression and intermittent anxiety attacks. Dr. Miller reported the Claimant's diabetes as poorly controlled in an April 2002 examination. Later 2002 examinations attributed complaints of muscle aches and flushing to medication. The January 9, 2003, and February 25, 2003, examinations tracked stable blood pressure and signs of anxiety.

B. **Medical Treatment Related to the Period Commencing April 16, 2003**

After Dr. Spear opined on April 16, 2003 that the Claimant had reached a plateau in his physical therapy, a functional capacity evaluation was completed April 21 and 22, 2003, at the Sports Therapy and Industrial Medical Center by physical therapists, Andrea Powell and Peter Owen. The physical therapists reported that the Claimant "put forth an acceptable effort in tasks and activities asked of him, however demonstrating a great deal of frustration and anxiety regarding his inability to perform at higher levels. No gross symptom magnification concerns are raised. Self-limiting was seen based on symptom response patterns with any forceful exertion or in a situation where co-contractions of the upper back or neck musculature is involved." (EX 2) On April 30, 2003, Dr. Spear reviewed the report of functional capacity evaluation "and agree[d] with findings completely that the patient is capable of performing sedentary work only." (CX 4 and EX 1) Dr. Spear discussed long-term medications, issued prescriptions, and referred the Claimant back to Dr. Koen for follow-up and review of the functional capacity evaluation.

The Claimant returned to Dr. Koen on June 4, 2003. A cervical MRI was completed on June 24, 2003, and reviewed by Dr. Koen on July 7, 2003. Dr. Koen diagnosed progressive degenerative cervical spine disease, opined the Claimant "basically has reached the end of conservative management" and recommended an anterior cervical discectomy and fusion with plating. (CX 3) No work restrictions were reported by Dr. Koen.

On August 6, 2003, the Claimant was seen by neurosurgeon Dr. Ordonez for a second opinion on the proposed neck surgery. Dr. Ordonez examined the Claimant, reviewed the cervical MRI and recent EMG, opined that the Claimant's right carpal tunnel syndrome could have been exacerbated by his fall, and recommended the Claimant "undergo C5-6 and 6-7 anterior cervical discectomy followed by C5-6 and 6-7 arthrodesis using either left iliac crest bone graft or allograft followed by C5-7 anterior cervical instrumentation." (CX 8) No work restrictions were reported by Dr. Ordonez.

By letter dated August 8, 2003, Dr. Koen stated that the interval progression of the Claimant's cervical disc disease, since treatment of the C5/6 and C6/7 disc herniations resulting from the May 1999 work injury, was not due to an injury but that it seemed the injury initiated the process of degeneration. When the Claimant was seen for a pre-operative conference on September 17, 2003, Dr. Koen reported the Claimant had atrophy in the triceps bilaterally and decreased sensation in the C6 and C7 nerve root distributions. Dr. Koen opined that the Claimant had "basically failed conservative management … [and] would benefit from C5-6 and C6-7 anterior

cervical discectomy and fusion with bone graft and plating." (CX 3) The Claimant agreed to surgery and was referred to Dr. Stein for cardiac clearance.

The Claimant returned to Dr. Spear on October 1, 2003, for additional injection therapy. Dr. Spear declined to comment on the surgical recommendations of Dr. Koen and Dr. Ordonez. Dr. Spear recommended that the Claimant avoid exacerbating activities.

Dr. Miller reported the August 25, 2003, examination revealed the Claimant as very anxious with an elevated blood pressure reading due to anxiety and well-controlled diabetes. By November 11, 2003, Dr. Miller reported the diabetes control as suboptimal. He reported a November 13, 2003, nerve conduction study/EMG of the lower extremities as indicating evidence of diabetic sensory neuropathy but no evidence of radiculopathy. By December 2, 2003, the blood pressure remained adequately controlled on Coreg, the diabetes was reported as not being out of control at present, and the leg symptoms did not require any specific therapy at that time. Dr. Miller encouraged the Claimant to follow-up with his neurosurgeons on making a decision about his neck condition.

On January 6, 2004, the Claimant saw Dr. Gurtner for a third medical opinion on neck surgery. Dr. Gurtner reported palpable muscle spasms in the cervical and thoracic region, mainly right-sided, no obvious atrophy, decreased sensation and grip in the hands, and decreased sensation in both feet with some decreased position sense. Dr. Gurtner reported the December cervical MRI as revealing neuroforaminal narrowing at C5-6, C6-7, and left side C3-4 without significant cord compression. Dr. Gurtner opined that she did "not think that he will benefit from additional surgery at this point … [and] further conservative management is indicated in regard to the muscle spasm." (CX 1) She advised better control of the diabetes and to follow-up MRI in one year. Dr. Gurtner reported "his activities need to remain restricted and lifting beyond 10 lbs. or pulling beyond 10 lbs. as well as overhead work or repetitive bending are not allowed." (CX 1) He was prescribed medication and three months of five days/week physical therapy and directed to return in one year with a new MRI.

The Claimant returned to Dr. Spear for injection therapy on January 23, 2004, March 19, 2004, May 28, 2004, August 27, 2004 and November 12, 2004. Dr. Spear reported during the May 28, 2004, session that from a non-neurosurgical standpoint he tended to agree with Dr. Gurtner's assessment that a wait and see approach would be best at that time. Dr. Spear's recommendation to the Claimant was to "avoid exacerbating activities and continue home exercise routine long term." (CX 1) At the November 12, 2004, examination Dr. Spear reported some mild diabetic neuropathy and cautioned the Claimant about foot clearance.

The Claimant returned to Dr. Gurtner on January 12, 2005, following a January 5, 2005, cervical MRI. Dr. Gurtner reported that the MRI showed essentially no change. The clinical examination was reported to be slightly worse than the prior year with new bicep and tricep weakness and increased neck stiffness. Dr. Gurtner "offered surgery directed to C5-6 and C6-7 using an anterior approach with cadaver bone and plate. However, since his diabetes is still under poor control, I advocate to maximize his glucose control and then reassess." (CX 1) By letter dated February 28, 2005, Dr. Gurtner stated that a functional capacity evaluation would not be helpful in this case and that even if the Claimant "does not have surgery, it would be

appropriate to continue with restrictions I have given to him on 1/06/04. I advised at that time not to lift beyond 10 lbs. or not pull beyond 10 lbs. as well as to stop all overhead work and all repetitive bending." (CX 1) By letter dated June 22, 2005, Dr. Gurtner reported that the Claimant had not returned to her office, that her January 2004 opinion of no benefit from additional surgery at that point was based in part because of no significant cord compression on the December 2003 cervical MRI, that her January 2005 offer of surgery was based on clinical progression without much change in the January 2005 cervical MRI, that the work restrictions in the February 2005 letter were because "excessive lifting, repetitive bending or overhead work would exacerbate the existing neuroforaminal stenosis at C5-6 and C6-7 … [and] he would loose more neurological function." (CX 1) Dr. Gurtner opined that "due to his other medical conditions, in particular a significant Type II diabetes along with coronary artery disease and hypertension, [the Claimant] is not able to tolerate a stressful work environment" (CX 1).

The Claimant subsequently saw Dr. Gurtner in consult for Dr. Miller on October 6, 2005. At that time the Claimant reported he had stopped all medications for the prior two months. Examination indicated depression and progression of the cervical stenosis as well as a need for evaluation of the lumbar spine. Dr. Gurtner renewed two prescriptions, started the Claimant on Elavil, and referred him to psychologist William Doyle for a chronic pain and depression consult. By letter dated October 18, 2005, Dr. Gurtner opined about the Claimant that "medically he is in no condition to carry out jobs for which I approved him … [and] altogether taking the exam from October 6, 2005, as well as the patient's work history and education history, I can no longer approve the job titles of dispatcher, police telecommunicator, contact lens lab technician inspector, small parts assembler, travel counselor service representative and lot attendant valet as well as unarmed security guard." (CX 1)

On October 17, 2005, the Claimant began seeing psychologist W.W. Doyle, PhD., for depression, pain, and increased irritability. Major depression, recurrent, severe was diagnosed. Weekly individual therapy sessions were recommended, as was a medical provider to titrate the psychotropic medications. The weekly individual therapy sessions took place on October 31, 2005, and in November 2005 on the 8th, 14th, and 28th. The psychologist "hypothesized that the [Workers' Compensation] payment reduction may have increased his irritability and worsened his depression, since he had never referred during the 5-6 prior years when he was coping with the multiple losses and gains from his injury." (CX 2) The Claimant declined to take anti-depressant medication as part of his treatment plan. The psychologist did not address any work restrictions.

Dr. Gurtner saw the Claimant in follow-up on October 26, 2005, after October 19, 2005, cervical and lumbar MRIs. Dr. Gurtner reported the cervical MRI as unchanged and the lumbar MRI as revealing a L5-S1 disc herniation. She opined that emergency surgery was not indicated but that he would be set up for the planned anterior cervical disectomy and fusion at C5-6 and C6-7 once his depression had lifted and he was medically stable to undergo extensive surgery.

The Claimant returned to Dr. Gurtner on April 20, 2006, with increased symptoms in the spine, upper extremities, and lower extremities. He was depressed and angry. Dr. Gurtner opined that the cervical disease may have progressed and an updated cervical MRI was required. She prescribed additional medication for the muscle spasms as well as 16 weeks of aqua therapy.

When seen on May 16, 2006, after the April 27, 2006, cervical spine MRI, Dr. Gurtner reported the MRI showed the same pathology but the clinical examination was worsening. Dr. Gurtner opined that the cervical surgery "will help his severe neck pain and bilateral arm pain and may improve the numbness in the hands and may even improve the strength of his grip, but I have serious doubts that it will effect the gait disturbance or the mild clonus which we have observed." (CX 1) Dr. Gurtner directed the Claimant to stop aspirin and Glucophage if he wanted to proceed with the neck surgery. She also opined that a brain MRI to rule out possible neoplasm or multiple strokes was warranted prior to surgery.

Dr. Gurtner provided deposition testimony on June 15, 2006. She testified that in an October 18, 2005, letter she opined that the Claimant was unable to handle the stress of certain jobs and could not handle instructions because of his medical condition and depression. She opined that the Claimant was medically incapable of carrying out any jobs as of October 2005 and that the condition continued. She reported that during an April 20, 2006, examination the Claimant was still too depressed and unable to handle surgery. Her examination indicated no neck extension, severe limitation in the range of motion in the neck, spontaneous myoclonus and fasciculations in both lower extremities, weakness in biceps, triceps and bilateral grip, decreased sensation in the right hand, ataxic gait, depression, anger, and peripheral neuropathy. She prescribed 16 weeks of aqua therapy for the neck muscle spasms. Dr. Gurtner reported that without neck surgery the Claimant was at maximum medical improvement. Dr. Gurtner testified that she diagnosed the Claimant with depression because he had abandoned medical treatment, was aggravated, agitated and aggressive toward her and his wife. Dr. Gurtner reported testified that if the Claimant's only problems were related to the neck he probably would be working and if neck surgery was successful, the lift and pulling restrictions would go up to 20 pounds. She also testified that starting in October 2005 she had always advised the Claimant she did not expect anymore useful employment from him and not to go back to work

C. The Claimant has been "temporarily" disabled since April 16, 2003

The Claimant has established progressive degenerative cervical changes as a result of the work-related May 27, 1999, injury and subsequent July 26, 2002, operation. The progressive degeneration affects his use of the upper right extremity, neck movement, muscle control, pain level, and mental well-being. Escalating conservative treatment consisting of medicines, physical therapy, aqua therapy, home exercise routine, pain relieving injections, and counseling have resulted in a plateau of pain control (Dr. Spear on April 13, 2003) and had basically reached the end of conservative management by July 7, 2003 (Dr. Koen). Two neurosurgeons (Dr. Koen in July 2003 and Dr. Ordonez in August 2003) found that the Claimant would benefit from a C5-6 and C6-7 anterior cervical discectomy and fusion with bone graft and plating. Surgery was scheduled and a pre-surgical conference was held on September 17, 2003 with Dr. Koen, but the Claimant failed to follow-through with the surgery. Instead, he sought a third neurosurgical opinion from Dr. Gurtner who saw the claimant once on January 6, 2004, and based on a December 2003 cervical MRI, as well as the Claimant's representations, stated that the Claimant would not benefit from additional surgery at this point but should receive further conservative management, get better control of the diabetes, and follow-up in one year. One year later the Claimant returned to Dr. Gurtner who then joined her colleges and offered the Claimant surgery directed to C5-6 and C6-7 using an anterior approach with cadaver bone and plate. Dr. Gurtner

testified that the recommended surgery would assist in controlling his severe neck pain and bilateral arm pain, may improve the numbness in the hands, and increase his lifting and pulling capacity to 20 pounds. Without the surgery Dr. Gurtner restricted the Claimant for lifting beyond 10 pounds, pulling beyond 10 pounds, performing overhead work and repetitive bending. It is noted that these restrictions are more descriptive than the general limitation to sedentary work reported by Dr. Spear on April 30, 2003. However, the medical evidence as a whole demonstrates that surgical intervention now recommended by all three neurosurgeon is medically expected to result in an increase in function and decrease in pain and muscle spasm related to the progressive cervical disease.

The Claimant has failed to establish good cause that would preclude surgery, such as religious grounds. However, the Claimant has established a sound medical reason why the surgery must be delayed beginning October 6, 2005. That is his depression and other medical problems of diabetes, hypertension and history of coronary artery disease must be stabilized prior to surgery and his depression is not yet stabilized (Dr. Gurtner). The Claimant has failed to demonstrate that his psychological condition is at maximum medical improvement. No medical doctor has reported such stagnation related to the mental health treatment. The Claimant has demonstrated that he stopped counseling with the referred psychologist after six weeks in 2005, has refused anti-depressive medication and titration, and does not participate in any further medical regimen directed at improving his psychological health.

After deliberation on all the evidence of record, this Administrative Law Judge finds that the Claimant's physical condition related to the May 27, 1999, work-related injury has not reached maximum medical improvement and would be improved substantially upon completion of the medically recommended cervical fusion which the Claimant cancelled; that the Claimant's psychological condition resulting from his physical condition has not reached maximum medical improvement and would be improved substantially if the Claimant would comply with the recommended medical regimen; that while the Claimant's physical condition related to the May 27, 1999, work-related injury has continued for a lengthy period of time, the condition is not of a lasting or indefinite duration if the Claimant complies with the recommended medical regimen; and that the Claimant's psychological condition from October 2005 has not been of a lengthy period of time nor established to be of lasting or indefinite duration when the Claimant complies with the recommended medical regimen. Accordingly, the Claimant's work-related disability is of a "temporary" status since April 16, 2003.

II. Claimant's Temporary Disability as "Total" through May 16, 2005 and "Partial" for the Period Commencing May 17, 2005 and Continuing.

Once the Claimant has established disability under the Act, the disability is considered to be a "total" disability if the employer fails to establish that suitable alternate employment exists for the Claimant when the Claimant's age, education, work history and work-related medical restrictions are considered. If suitable alternate employment exists, the disability is classified as "partial" if the suitable alternate employment did not provide the claimant at least the same income realized by the claimant in the pre-injury employment position. The date when a temporary / total disability becomes a temporary / partial disability is the date when the employer meets its burden of establishing suitable alternate employment. *Hogan v Schiavone Terminal,*

Inc., 23 BRBS 340 (1992). The employer may rely on the testimony of a vocational rehabilitation expert to satisfy its burden. *Southern v. Farmers Export Co.*, 17 BRBS 64 (1985). Testimony from a non-vocational expert, even if from a treating physician, stating that the claimant cannot work, will not be sufficient to rebut creditable testimony from a vocational expert, unless the non-vocational expert knows the specific requirements of each job identified. *Villasenor v. Marine Maintenance Industries, Inc.*, 17 BRBS 99, 103 (1985); *see also Sutton v. Genco, Inc.*, 15 BRBS 25, 27 (1982) (holding that a treating physician's vocational opinion can properly be discredited by an Administrative Law Judge ("ALJ") as beyond the physician's expertise). However, an ALJ should consider all physical and psychological limitations of record given by treating physicians when evaluating the claimant's ability to perform a specific job identified by the vocational expert. *Id.*

A. The Employer has failed to establish any suitable alternate employment before May 17, 2005.

The LS-208 contained in EX 7 documents payments to the Claimant for temporary / total disability compensation from November 14, 2001, through September 19, 2005, at the weekly rate of $561.80. The Parties have stipulated that the Claimant cannot return to his pre-injury employment due to his work-related May 27, 1999, injury. Additionally, the record is void of any evidence prior to May 17, 2005, that suitable alternate employment existed which the Claimant could perform. Accordingly, the Claimant is entitled to temporary / total disability compensation at the rate of $561.80 per week for the period from April 13, 2003, through May 16, 2005, inclusive.

B. The Employer has established suitable alternate employment has existed as of May 17, 2005.

On April 16, 2003, Dr. Spear stated that the Claimant had "reached a state of plateau with regard to further physical therapy efforts" and directed a functional capacity evaluation, which was completed by two physical therapists. On April 30, 2003, Dr. Spear reviewed the report of functional evaluation and reported that the Claimant was capable of sedentary duty only and could not return to his pervious job. During the series of injections he gave to the Claimant in 2003 and 2004, Dr. Spear continued to reiterate that the Claimant should not do any activity that would exacerbate his condition, without any further clarification.

Neither of the original neurosurgeons who examined the Claimant in treatment (Dr. Koen) and consultation (Dr. Ordonez) placed work restrictions on the Claimant, though both recommended cervical surgery (on July 7, 2003 by Dr. Koen and August 6, 2003 by Dr. Ordonez). Even the family physician (Dr. Miller) failed to place work restriction upon the Claimant.

The third neurosurgeon, Dr. Gurtner, initially examined the Claimant on January 4, 2004, and directed that he not lift or pull more than 10 pounds, not perform overhead work, and not perform repetitive bending. It is specifically noted that these work restrictions are more limiting than the broad limitation to "sedentary work only" expressed by Dr. Spear. Dr. Gurtner examined the Claimant the second time on January 12, 2005. She reiterated the same limitations in letters to the case manager on February 28, 2005, and June 22, 2005.

On March 30, 2005, the Vocational Expert sent a letter to the Claimant setting forth April 5, 2005, as a meeting date for the vocational interview. By letter dated March 31, 2005, the Claimant, through his attorney, advised the Vocational Expert that the Claimant "will not be meeting with you on Tuesday, April 5, 2005, at 2:00 p.m., or at any time, unless required by some higher authority." (EX 4)

On May 17, 2005, the Vocational Expert issued a written Labor Market Survey Report. The report indicated that the survey was completed without the Claimant's involvement in vocational rehabilitation services, that the Claimant's work history had been considered and that medical records through January 28, 2005, had been reviewed and the limitations set by Dr. Gurtner were applied. The Vocational Expert identified ten jobs that were reasonably available in the local community that the Claimant could perform given his known profile. These jobs included dispatcher with Manpower and an appliance store, dispatcher trainee and call taker with the City of Chesapeake, emergency coordinator II with the State Police, lab technician with a contact lens company placed through a staffing company, small parts assembler for a light manufacturer, auto travel counselor with AAA of Tidewater, service department valet for an automobile dealership, and unarmed gate guard for a local company. On July 29, 2005, Dr. Gurtner approved each of the job descriptions specifically identified by the Vocational Expert as potential work for the Claimant. (EX 4) It is specifically noted that Dr. Gurtner approved each of the job descriptions one month after she advised, in a letter to the Claimant's attorney on June 22, 2005, that due to the Claimant's "Type II diabetes along with coronary artery disease and hypertension, [the Claimant] is not able to tolerate a stressful work environment [and] I hope this will be taken into consideration when identifying employment options for [the Claimant]. (CX 1 and CX 12) There is no reason to believe that Dr. Gurtner did not consider this specific factor herself when she approved the job descriptions on July 29, 2005.

On October 6, 2005, Dr. Gurtner reported by letter to the Claimant's family physician, Dr. Miller, that the Claimant had stopped taking all of his medication for the past two months, that the Claimant's blood pressure was elevated at 180/120 (whereas Dr. Gurtner had reported the vital signs as stable in her prior examinations of the Claimant), and that his findings were suggestive of depression but also the progression of the cervical stenosis. Dr. Gurtner prescribed the anti-depressant Elavil and referred the Claimant to a psychologist. (CX1 and CX 12)

By letter dated October 18, 2005, Dr. Gurtner advised the Vocational Expert that based on the October 6, 2005, examination she found the Claimant "was quite depressed … In particular, he had developed more symptoms." She stated that "Altogether I think that medically he is in no condition to carry out the jobs for which I had approved him." Dr. Gurtner went on to state that she "was misled by the statement that the job descriptions [approved by her on July 29, 2005] … were selected based on the patient's age, education and work history. As I learned through [the Claimant's attorney] today, [the Claimant] has completed an eighth grade education and has a work history as a diver. Retrospectively I regret that I was unaware of these limitations when initially signing off on the job descriptions you presented." (CX 1) However, during her deposition of June 16, 2006, Dr. Gurtner testified on cross-examination that "I didn't think he was that poorly educated after my first meeting .. he was a supervisor for a diving company. I thought he had to manage some papers … you know, keep records on his dives and on his employees." She further testified that the Claimant had abandoned medical treatment by the

October 6, 2005, examination and she could no longer approve the jobs previously approved by her on June 29, 2005, because of "the exam from October 6, 2005, as well as the patient's work history and education history." She testified that the Claimant "was unable, because of his medical conditions and his depression to handle instructions" and because he "had only completed an eight grade education, was unable to take the stress of any job which required work as a police communicator, contact lens tech/inspector, small parts assembler, travel counselor, service representative or lot attendant/valet or an unarmed security guard.". She reported that "after what I had seen October 6th, 2005, he was medically not capable [to carry out any jobs as of October 2005]." Dr. Gurtner testified that the Claimant was still too depressed and unable to handle stress at the April 20, 2006 examination or to undergo the recommended cervical surgery. (CX 12) This specific sequence of events demonstrates that Dr. Gurtner thought the Claimant could do the jobs she approved on July 29, 2005, based solely on the Claimant's medical condition and that she believed he could not do the jobs after he abandoned his medical regimen in the August to October 6, 2005 timeframe. Since Dr. Gurtner has not been qualified to make opinions within the realm of a vocational expert, her opinion as to the ability to perform described jobs based on education and work history are given little weight.

Subsequent to an Order to appear before the Vocational Expert, the Vocational Expert met with the Claimant on May 9, 2006. She completed a personal interview of subjective complaints, social history, educational background, work history and formal vocational testing as well as a review of medical records. The Vocational Expert revised the proposed list of possible employment to reflect the vocational limitations set forth by Dr. Gurtner, the Claimant's work history, age and limited educational abilities. These possible employment positions included two lot attendant positions, two cashier positions, cashier/museum guide, two unarmed security guard positions, driver, parking cashier, cashier/sale associate, and toll collector. At the hearing the Vocational Expert testified that the Claimant's presentation and ability to interact with people were excellent assets appropriate for the jobs in public places as cashier, museum guide, unarmed security guard, parking cashiers, toll collectors, and automobile parking lot attendants. She testified that after meeting with the Claimant, the previously described jobs in the dispatcher occupational base were not appropriate because they required a high school diploma, which the Claimant had not acquired. The Vocational Expert testified at the hearing that the service valet for cars identified in the 2005 market survey was still an appropriate job, as were the jobs identified in the 2006 market survey. It is specifically noted that the jobs involving cahier work, toll collection and parking lot attendants are generic in nature and generally reasonably available. There is no reason to believe that they would not have been reasonably available in May 2005 as well as May 2006. This Administrative Law Judge specifically finds that the Claimant's failure to cooperate with the Vocational Expert in April 2005 misdirected the Vocational Expert in the evaluation of the Claimant's educational history and that had the Claimant provided information similar to that he provided in 2006, the jobs included in the 2006 Market Survey Report would have been more timely reported and identified to specific employers.

The Claimant willfully failed to attend and cooperate with the Vocational Expert for a scheduled April 5, 2005 interview. This failure to cooperate withheld material information related to education from the Vocational Expert, and was not reflected in the medical and vocational information provided to the Vocational Expert at that time. The Claimant never applied for the positions identified in the 2005 report. (EX 4) There is no evidence that the Claimant ever

sought employment at any time after April16, 2003, even though he was provided job placement notices by the Vocational Expert on April 29, 2005 and May 2, 2005. There is no indication that the Claimant has followed-up on any of the positions identified in the 2006 report.

The medical evidence established that the Claimant abandoned his medical regimen in August 2005 and continued through to the October 6, 2005 examination by Dr. Gurtner. The medical evidence submitted from the psychologist documents the Claimant's refusal to accept anti-depressant medication as a necessary part of the three realms of mental health treatment for his mental condition and the Claimant's abandonment of mental health counseling in November 2005. (CX 2) CX 10 does indicate that the Claimant picked up a thirty (30) day supply of Zoloft for the morning and Trazadone at bedtime as prescribed by the family physician on December 19, 2005, at the recommendation of the psychologist. The prescription included a one time refill which was expected to cover the period until the Claimant would return to Dr. Miller for a regular scheduled appointment. At the hearing the Claimant testified that he still took the prescribed Zoloft and sleeping pill but that he has not seen a medical provider since November 2005. Dr. Gurtner did not prescribe any anti-depressant or sleeping medication after the October 6, 2006 examination.

A claimant must reasonably cooperate with his employer's rehabilitation specialist and submit to rehabilitation evaluations. *Vogle v. Sealand Terminal*, 17 BRBS 126 (1985); *Villasenor v. Marine Maintenance Industries*, 17 BRBS 99 (1985). Additionally, the Administrative Law Judge must consider any failure to cooperate in evaluating the vocational expert's testimony. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532 (1979). The claimant must also establish a reasonable diligence in attempting to secure some type of suitable employment within the type of suitable alternate employment opportunities shown to be reasonably attainable and available, and must establish a willingness to work. *Trans-Slate Dredging v. Benefits Review Board (Tarney),* 731 F.2d 199 (4th Cir., 1984); *Newport News Shipbuilding and Dry Dock Company v. Tann*, 841 F.2d 540 (4th Cir., 1988).

Section 907(d)(4) of the Act provides that if an employee unreasonably fails to submit to medical or surgical treatment the payment of further compensation may be suspended during such time the refusal continues. However, such suspension may not be applied retroactively and does not apply prior to the employer's raising the issue. *Dodd v Newport News Shipbuilding and Dry Dock Co.*, 22 BRBS 245 (1989). The Fourth Circuit Court of Appeals has held that that where the employee's refusal to submit to medical or surgical treatment is unjustified under the Virginia state workers' compensation proceeding, the disability compensation must be suspended. *Pettus v American Airlines*, 587 F.2d 627 (4th Cir., 1978). Here the employer has not raised the issue of suspension of compensation benefits under Section 907(d) of the Act. However, the Claimant's abandonment of medical treatment is relevant to his credibility, suitability of alternate employment when compliant with the medical regimen, and willingness to work.

After deliberation on all the evidence of record, this Administrative Law Judge finds that the Employer has established suitable alternate employment for the Claimant as of May 17, 2005, and that the Claimant has failed to rebut the suitability of the alternate employment by credible

and competent evidence. Accordingly, the Claimant is entitled to temporary / partial disability compensation beginning May 17, 2005.

The service valet position identified in the 2005 report was a full-time 40 hour work week position that paid $7.50 per hour ($300.00 per week). Of the eleven jobs set forth in the Vocational Expert's 2006 market survey, eight are full-time 40 hour work week positions paying between $6.00 and $8.00 per hour ($240.00 to $320.00 per week). The cashier/museum guide paid between $225.00 and $286.00 per week. The rental car driver paid between $210.00 and $224.00 per week. The parking lot cashier paid between $140.00 and $196.00 per week. The full-time Greenbrier Volkswagen service valet identified in the 2005 market survey paid $7.50 per hour ($300.00 per week). The Vocational Expert testified that the 1999 wage range for the listed jobs was $5.25 to $6.00 per hour ($210.00 to $240.00 per week). This Administrative Law Judge finds that the evidence of record establishes that the 1999 average weekly wage of the suitable alternate employment for the unskilled, entry-level positions was $210.00 per week and the Claimant's average weekly wage at the time of injury was $842.70, as stipulated. Accordingly, the Claimant is entitled to a temporary / partial disability compensation rate of $421.80 per week (two-thirds of the difference between $842.70 and $210.00) commencing May 17, 2005 and continuing.

III. Non-availability of Special Fund Relief Pursuant to 33 U.S.C. § 908(f)

When an employee becomes permanently totally disabled, his employer will only be responsible for 104 weeks of disability benefits, if the employee had a pre-existing permanent partial disability that contributed to the permanent total disability. 33 U.S.C. § 908(f)(1) (2000); *Director, OWCP v. Newport News Shipbuilding and Dry Dock Co. (Langley)*, 676 F.2d 110, 112 (4th Cir. 1982). The remainder of the employee's disability benefits will be paid out of a special fund set up under 33 U.S.C. § 944. 33 U.S.C. § 908(f)(2)(A). However, before the employer is entitled to § 8(f) relief, the employer must establish: (1) a pre-existing permanent partial disability; (2) that disability must be manifest to the employer; and (3) "the pre-existing disability must combine with the subsequent disability and contribute to the resulting permanent total disability." *Langley*, 676 F.2d at 114. Here, a permanent total disability status has not been established which would permit consideration of Special Fund Relief. Accordingly, the Employer is not entitled to Special Fund Relief pursuant to 33 USC § 908(f).

CONCLUSION AND FINDINGS OF FACT

After deliberation on all the evidence of record, including post-hearing briefs of counsel, this Administrative Law judge finds:

1. The Claimant suffered a compensable cervical spine injury while in the course and scope of his employment with Employer on May 27, 1999.

2. The Claimant gave timely notice to the Employer of the work-related injury.

3. The Claimant cannot return to his pre-injury employment with the Employer.

4. The Claimant's average weekly wage was $842.70 at the time of the injury.

5. The Claimant was temporarily / totally disabled from April 16, 2003 through May 16, 2005, inclusive.

6. The Claimant has been temporarily / partially disabled since May 17, 2005.

7. The Employer is not entitled to Special Fund relief pursuant to 33 U.S.C. § 908(f).

8. The Claimant is entitled to temporary / total disability benefits at the rate of $561.80 per week for the period April 16, 2003 through May 16, 2005, inclusive.

9. The Claimant is entitled to temporary / partial disability benefits at the rate of $421.80 per week for the period commencing May 17, 2005 and continuing.

10. The Employer has paid temporary total disability benefits at the rate of $561.80 per week from November 14, 2001, through September 19, 2005.

11. The Employer has paid permanent partial disability benefits at the rate of $281.70 per week since September 20, 2005, and continuing.

ORDER

It is hereby ORDERED that:

1. The Employer, Crofton Diving Corporation, shall pay compensation to the Claimant as follows:

    a. weekly compensation at a rate of $561.80 for temporary/total disability benefits during the period April 16, 2003 through May 16, 2005, inclusive; and,
    b. weekly compensation at a rate of $421.80 per week for temporary/partial disability benefits during the period commencing May 17, 2003 and continuing.

2. Employer shall receive credit for all related disability benefits previously paid to the Claimant commencing April 16, 2003.

3. Interest at the rate specified in 28 U.S.C. § 1961 in effect when this Decision and Order is filed with the District Director shall be paid on all accrued benefits computed from the date on which each payment was originally due to be paid.

4. All monetary computations made pursuant to this Order are subject to verification by the District Director.

5. Employer shall provide such reasonable, appropriate, and necessary medical treatment as the nature of the Claimant's work-related cervical spine based disability requires pursuant to § 907 of the Act.

6. Within twenty (20) days of the receipt of this Decision and Order, the Claimant's attorney shall file a fully itemized and supported fee petition with the Court, and send a copy of same to opposing counsel who shall then have fifteen (15) days to respond with objections thereto.

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ALAN L. BERGSTROM
Administrative Law Judge

ALB/MSW/jcb
Newport News, Virginia